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PRESIDENTIAL ADDRESS[1]

Our Association in a Time of Unsettlement

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The woes of him who essays to compose a presidential address to the oldest national medical society in the United States have been set forth so vividly by my predecessors, Dr. Callender in 1883 and Dr. Blumer in 1903, that I need not impress on you the thought, the concern, the worry and the insomnia that are involved. One more terror was added when the review of all the addresses for the centennial number of the Journal condescendingly used the terms ritual, pedant, humbug, platitudes, generously forgotten, uninspired, doldrums, lethargy, fog of inertia. Fortunately another 47 years may roll by before another review is written and your president as of 1947 will therefore disregard what will later be said about him by someone perhaps to be born next year. Since 1883 these addresses have been given, apparently in all seriousness. Some were historical, some prophetic, some philosophical.

A friend has pointed out that it is an especial privilege to hold this office in this exceptional period, for everything seems to be in flux. The Association is like the Mississippi when Mark Twain was a pilot; what are sturdy and respectable banks and bars today may be all washed out by tomorrow and a new course will have to be charted, midst new sands and snags. So one might discuss anything with the expectation that it was recently timely, is timely now, or will be timely by the end of the month. Let us consider first what is holding fast in Association procedure, and what is washing away.

When we gather in conclave we find ready prepared for us a mass of experience and opinion. Workers from a hundred places will tell us the story of their work, whether the work of service or the work of study. Some have views about what has been done by the Association, by the armed forces, by the staff of some hospital, by the neighbors who have gone to prison or the neighbors who go about the streets. This have we done for more than a hundred years and though some decry it and talk of relegating such papers to subdivisions of the Association so that more time may be left at the convention for presenting a few particular orations, I hold that our usual course has been useful and should not be lightly abandoned. Said one of our most highly regarded leaders, the greatest service of the Association is to offer opportunity for free discussion. Hundreds of us go from these meetings tired but inspirited, and in consequence do our whole year's work better.

A vast amount of preliminary thought comes from our committees and we will briefly review their position. At the very first meeting of the Association, 16 committees were set up. The chairmanships were divided among ten members. Dr. Brigham held three posts, Drs. Butler, Kirkbride, Ray and Stribling two each, and Drs. Awl, Bell, Earle, Galt and Woodward one each. These committees were to consider moral treatment, medical treatment, and restraint; construction, organization, and chaplains of hospitals; prevention of suicide, advantages of private treatment, autopsies, and prevention of mental disease; statistics, jurisprudence, public support; and provisions for prisoners, Negroes, idiots and demented persons. The reports of committees furnished the backbone of the program for several years; this was natural, for a committee report was mostly an essay by the chairman. Committee reports are now decried in some quarters, printed in small type and not always read. Committeemen sometimes question whether the return on their labors justifies the time they give to their responsibilities. No committee should feel offended or even discouraged when their recommendations seem to get merely a respectful hearing and no action, for if they point the right road, it will be

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traveled when someone devises a practical conveyance.

For example, some years ago the Committee on Research urged that clerical help be granted so that the committee could keep account of all research going on in our territory, give counsel and perhaps find support for promising projects. We are not a wealthy organization and never saw our way to supply that clerical help. Now the Federal Government has made psychiatric research its concern, and when the National Mental Health Council gets its funds, every research in our field will be a matter of interest, and many worthy projects will be subsidized.

Our long list of committees shows the varied interests of our membership. They number 31. Most committeemen consider appointment an honor, though some perhaps continue to serve from a sense of duty rather than choice. By spreading these duties widely, we bring more members into the work. Our officers, our special representatives and our committeemen this year include over 200 Fellows and Members. During the war we were deprived of the participation of many of our ablest members who were in military service. It has been my privilege to appoint an unusual number of recent veterans to committee posts, since they came home just before my term started. Five chairmen found it necessary to withdraw, to our regret. We were fortunate to get Drs. Chambers, French, Lewis, Tiebout and Woolley to take these posts. Two new committees are headed by Drs. Himler and Pratt.

Of these committees 12 have held a meeting—perhaps more than one—during this operating year. The tradition of the organization has been that committee meetings should be few, for they cost money. At present we are in position to authorize more of them, and I have encouraged holding meetings. I hope that you will ask your councillors to continue this policy. Of all the ways of spending our funds, even at the penalty of reducing our treasury nest-egg, this is in my opinion one of the most fruitful. The $4,600 spent has been a good investment. Bringing a committee together does more than assure the consideration of certain items. It also enables the younger members to understand better the scope of the Association, its influence on what is happening in our field, and the prime fact that we do our most effective work through our individual members rather than by distant pontification—shouting at people across space.

A few committees have been set up to meet special situations and two function only for a year. These shortlived ones are the Executive Committee and the Committee on Arrangements. The Executive Committee consists of three officers and two additional councillors, and carries on the business of the Association between meetings of the Council. I am grateful for the diligence and wisdom of this year's Executive Committee. The Committee on Arrangements works with the Program Committee and the executive assistant. They have admirable plans for making your visit pleasant.

When our membership was a few hundred and salaried positions in Canada and the United States numbered only a few more, a candidate could with a few letters canvass all the desirable openings in the field. As years passed, more and more positions were set up, and in this century more kinds of positions. Even before World War I, court and clinic and penitentiary—as well as hospitals—were employing psychiatrists. That war dislocated scores of our members and attracted new men into psychiatry. From 1911 the National Committee for Mental Hygiene had been a disseminator of information about vacancies and possible candidates. After that war the National Committee engaged one of our number to help the discharged military psychiatrist find a job to his liking, and persuaded some minor hospitals to appoint men of major training to their staffs. The same problem and opportunity transpired after this war. The financial position of this Association being favorable during Dr. Bowman's presidency, we appropriated money to strengthen greatly the personnel division of the National Committee by sharing the expense of what we have called the Psychiatric Placement Service, which included a director and a secretary. Over 900 returning veterans have consulted it in person or by letter. More than 60 took positions in public mental hospitals, some in private hospitals and some in other organizations. Much the largest number wanted

training, preferably in a university clinic. We would gladly have seen 600 go into hospitals, but such was not their temper. We think our money was well invested. We shared costs with the National Committee for a year and added enough to continue their clerical help six months longer in order to integrate the new information into their files. A joint committee supervised the work and has nearly completed its mission.

Special temporary committees were appointed by request to advise with the New York State Department of Welfare and the Chicago branch of the Civil Liberties Union.

The Committee on Research is dividing the field among its members and intends to keep informed and to inform us about what is in progress. They will be particularly interested in accessible unsolved problems. A special committee was set up in the previous administration to confer with leading psychologists on the relations between their discipline and ours. This committee has proceeded with cautious wisdom and is being continued while the psychologists develop schemes for accrediting sound clinical experience. The Committee on the Legal Aspects of Psychiatry will review for you their efforts during the last five years to obtain uniformity of commitment procedures, equitable treatment of legal offenders in the armed forces and extension of the teaching of legal psychiatry in colleges of medicine and colleges of law. They will also discuss the handling of juvenile delinquency and the question of legal responsibility for criminal activity.

Our Committee on International Relationships has an extraordinarily intriguing field today, one that may baffle the wisest of us. Perhaps we must pile an international organization on top of our national associations in order to be heard in international affairs. Our committee watches this situation and Drs. Chisholm and Rees will bring us information about what impends. Another relatively young committee is that on Preventive Psychiatry, a subject about which absurd things are sometimes heard. This committee seeks the implementation of what they call a modest program, through facilities that are already available in our educational institutions, such as schools of public health and departments of preventive medicine. The Committee on Military Psychiatry will tell you their discouragement over the conservatism of the military command and their view of great advances that are possible. The Committee on Veterans is influential in the very fine and effective program of the Veterans Administration in neuropsychiatry. Their report will inform us of progress there.

The Committee on Psychiatric Social Service maintains lines of communication all over our area and will give us current information about the state of social service in our hospitals, where standards may be good but too often are low. The Committee on Industrial Psychiatry started several years ago as a subcommittee. Its members, out of personal experience, will tell us of the great opportunities in that field and of the training and shrewd wisdom needed for the task.

Our biographical volume was published in 1941. Its usefulness has surpassed what many of us thought was possible and the supply was exhausted long before the information became obsolete. A special committee has laid plans for the compilation of a new volume. The cost will this time be greater and the book may not pay for itself as the old one did. The Council believes that it will be a sound investment in public relations and a great aid to our membership, particularly those who make appointments or seek candidates for important positions.

The Committee on Nomenclature and Statistics after several years of little responsibility now finds itself very much in the limelight because a new classification of mental diseases has emanated from the Army and is so well received that other organizations are considering its adoption. This committee, besides its own deliberations, will communicate with other medical organizations that are interested in the uniform classification, and in due time will give us their findings.

The Committee on Psychiatry in Medical Education with its customary industry has assembled facts about the teaching in our medical schools, which indeed has undergone considerable shift toward our position. This committee has had a very helpful influence on medical education. They are now considering how to put a mobile teaching group in the field. In this period when emphasis in

medical education is moving from the psychoses to the psychoneuroses, we should give every encouragement to sound and effective procedures. We do not want the medical student to come out of school with the idea that patients who respond well are the only ones worth thinking about, even though they may need more of his time than do men with severer ailments.

Our Committee on Ethics has listened to complaints and has taken up on its own initiative matters in which the reputation of members of our Association might be questioned. It is inevitable that professional men should make an error and overstep conservative practice now and then. It is absolutely unavoidable that some patient will complain of the way his affairs have been handled, and these complaints may be lodged against the most discreet as easily as against the incautious. Our Committee on Ethics takes its responsibilities with all seriousness and makes full reports to the Council; the essence of these reports is brought to the Association.

The Committee on Psychiatric Nursing has a broad stimulative influence on nursing educators in our field. Its present work can extend at least another three years through which a generous grant of the Rockefeller Foundation will continue. That Foundation happily sees high value in personal visits to the schools of nursing and accordingly we are able to have a nurse actually in the field. The committee and their representative are to be commended for the mobility they have displayed; it is more effective than writing exhortations, though of course incidental reports are a means of prolonging the effect of what has already been conveyed by word of mouth.

Our Committee on Public Education has continued its very effective work. On occasion the opinion of the Association, or the Council, or of some committee duly appointed to represent us should be recorded and heard. Indeed on such occasions our opinion and advice is not only heard but also recorded, as our newspaper clippings show. This work is often more effective because not attuned to a blare of trumpets. The loudest noise may fail to encompass the greatest wisdom. A wise man once remarked that he was not interested in turning the steam into the whistle but was deeply concerned about having a fire under the boiler. The committee sees some progress and will again remind us that good relations are based on our records as individuals and are likely to be best when least controversial. The expense of this work to the Association is so small that we are evidently indebted to private generosity.

The Committee on Membership has a large task every year, carried out mostly just before the annual meeting. In preparation for their scrutiny of 799 applications for admission or transfer, a huge amount of correspondence is carried on by the office, and this correspondence is not infrequently reviewed by a committee member or an officer. At the instance of Council the committee has this year made a survey of the associate membership with a view to promoting to membership those who have been in our ranks for three years and who persevere in psychiatry.

The Nominating Committee, sensing a desire to change our usual practice and leave part of the sifting of candidates to the assembly rather than require the committee to do the whole process, has brought to you multiple nominations for president-elect and for councillors. We hope the members will find ways to express their opinion of this procedure. It has already been criticized; one Fellow of the Association has said he dislikes to be opposing another at the polls. Undoubtedly it was time to experiment, whatever scheme turns out to be ultimately most acceptable.

Our Committee on Program has had to do more integration of special interests than usual this year, and they have done it skilfully. The Committee on Reorganization has made a heavy contribution to the program. This committee, originally appointed in 1944, included some of our liveliest spirits and represented a segment of our membership who have won distinction in teaching, in administration, in clinic, in private practice and in military service. Following their presentation at the Chicago meeting of what the Association should be doing and how to get it done, they asked and were promised more members and more time on this year's program. You have noticed that all day Tues-

day is devoted to two series of discussions of our work and our responsibility. I need not emphasize the importance of these sessions and the interest aroused in them under the brilliant leadership of this committee. The conclusions reached will be laid before you in resolutions Thursday morning. Any action taken at that session should represent your considered judgment, so far as possible.

Another matter seemed so important as to warrant a whole session this year. The Psychiatric Foundation is a monument to the vision and pertinacity of our executive assistant, Austin M. Davies. Its purposes and almost limitless possibilities, as well as its plan of action, will be spread before you Wednesday afternoon.

Meanwhile what has become of our usual scientific program? It has suffered cuts but has come out well. Feeling sure of a large attendance in New York we have taken five days for our meetings. Because of the urgency of our special programs, men from other walks of science will not be heard this year. The chief interest of the yearly meeting—the presentation of experience and theory by our rank and file—has been somewhat reduced. It may be a little harder to hear all the papers you wish because we have more quadruplet sessions than usual, a measure necessary to forestall a serious reduction in the number of communications presented.

We had hoped to sit at clinical sessions in some of our hospitals but in the pressure of new projects to consider, that item has to be deferred to a later year. In one regard we have made a definitely better arrangement of the program: round table discussions will be held on two evenings instead of one; fewer members need be disappointed because they cannot go to two of these interesting and important conferences.

Early in its history this Association set up standards that ought to be attained by mental hospitals. Those standards had great influence. After a time the formulations became less pertinent and fell into disuse. Partly as a result of the needs of the Federal Government in providing for the veterans of the first World War, a new set of standards was adopted and found its ablest expression in 1926 when, after a period of study by the Committee on Standards and Policies, they were presented to the Association for a year's consideration and were then adopted. They were intended as minima and in several instances have been modified and added to. They have been used effectively to bring about improvement in organization and equipment of mental hospitals in many places. No doubt further amendments will be needed and will be made. If made after due consideration and appropriately formulated, and not too rigid in detail, they will serve the mentally ill for years to come. Probably we are right in setting these standards so high that only the best supported institutions meet them all. So liberal a state as New York, for instance, did not provide quite the ratio of physicians to patients that was called for in the standard adopted in 1926, and stood farther below the later modification of that standard. On the other hand, most standards have been surpassed in various hospitals. We have succeeded in steering a middle course. Standards that can be never more than an aspiration would not be helpful to well-disposed public officials when they try to get better support for our hospitals. Standards that everybody has attained leave no room for striving.

Standards inevitably lead to questions about rating. Here we meet difficulties, and it is possible for desk workers to give formal ratings too high a value. The Mental Hospital Survey Committee staff worked a long while on the problem of ratings, but never found a satisfactory scale. The United States Public Health Service obtains information about mental hospitals and puts it to good use, but would be conservative about any scheme that would rate one hospital as number five in excellence and another as number 173. Our Committee on Standards and Policies has ambitious plans for rating the excellence of the mental hospitals of the country. They have sent out questionnaires and now have the promise of a grant from the Psychiatric Foundation to meet the expense of devising a rating scheme and doing something about it. They will need great wisdom in planning further moves in this matter.

We have designated several Fellows for

important liaison. Dr. Joseph W. Moore represents us in the American Association for the Advancement of Science. Drs. Lebensohn and Yerbury took part in the deliberations of the Inter-Society Committee on Science Foundation Legislation in February and Dr. Whitehorn represents us there. Dr. Burlingame was our delegate to the British Medico-Psychological Association. Drs. Curran and Schumacher participated in the Attorney General's conference on juvenile delinquency. Dr. William Leavitt was delegate to the annual meeting of the American Social Hygiene Association in New York and Drs. Keyes, Sands and Peatick to the American Academy of Sciences at Philadelphia.

Our JOURNAL enjoys deserved popularity and now has 2,168 subscriptions outside the membership. Among these are 87 subscriptions by medical students and interns, at half-price. It is intended this summer to begin publishing the JOURNAL monthly. In preparation for this expansion we have acquired an editorial assistant. We have raised the subscription price to ten dollars. Many in our membership have wanted more news about what is going on in psychiatry. To meet this desire the Council took tentative steps toward establishing a news sheet for a year's trial, not to compete with the JOURNAL but to supplement it. A committee was appointed and met the delay inevitable in such a project. Now the Council has decided to try for a year another plan, and get more news into the JOURNAL.

So much for our committees. Let us consider some strong and some weak points in our constitutional structure. The rising number of affiliate societies is an excellent development in the frame of the Association. The first affiliation was enacted only so late as 1934. The number of such societies grew slowly and the growth was healthy and spontaneous, no outside stimuli being applied. In 1943 when the affiliate societies numbered 11, the Council invited each affiliate to send a representative to sit at Council meetings and join in the discussions. This has worked well. The Association has made no contribution to the expenses of these delegates except a meal or two, when Council meetings extend through meal time. Five more societies have come in, and two await your decision.

Voices have been raised in favor of further elaboration. The bylaws provide for the establishment of district branches, on petition. If still more meetings and dues are wanted, this mechanism is ready. Perhaps we are doing better to ride for a while the current that is already swirling. Our members have been organizing groups according to local geography and lines of transportation, rather than with artificial boundaries. We are just receiving as affiliate a very important organization whose membership centers in New York City and includes members from parts of several states. I am sure nobody with a pair of shears would have cut out from the map a district just like that. A special committee might well study this matter.

Most of our business is handled, and well handled, by the Council. That body hears reports and passes on their fitness for transmission to the Association. It appropriates money. It expresses its will to officers and agents. It is a hardworking body of men who are earning their living at home, but giving this time and thought to their colleagues' affairs. The business has grown with the membership. Year by year a new president presides over the Association in course, and also has to preside over Council. No two presidents do it the same way. Council meetings are long and often tedious, and time is lost on matters that could be more expeditiously handled. If Council should select its own moderator, time and human effort would be saved. He might be a member of Council, but sometimes would not be. In that case, like the speaker of the British House of Commons, he would have no vote. His one job would be to get the business done in an orderly and economical fashion. Under that arrangement the president would be able to consider, to confer and to vote like other Councillors instead of being under continuous pressure to push the agenda. This change has found favor during informal discussions and notice of a suitable amendment has gone to the secretary.

Another matter needs attention. We have no constitutional provision for replacing a deceased or resigned official and might fall into serious fiscal embarrassment, with no-

body qualified to sign checks. An amendment will be introduced enabling Council to fill vacancies.

Before the war it was proposed that the president and a couple of interesting speakers should be a deputation to various parts of the country to participate in programs of related societies. The plan has merit, but it would be best to do nothing in the coming year that could be suspected of weakening our interest in the Portland meeting, for this is only the second time that the Association has placed its annual conclave on the Pacific Coast, and we wish a first-class meeting there, even better than the one at San Francisco in 1938. If the 1949 meeting be held in the East, there should be one or more meetings on the Pacific Coast for those who cannot cross the continent. A single gathering might be held at a central place such as San Francisco. Or the North Pacific Society, our members around San Francisco Bay, and our Southern California members might have separate meetings, their programs strengthened by a deputation chosen by our Program Committee. I recommend that our Coast members consider all this, and at Portland tell the Council just what they want in 1949.

In any organization of this size two trends of thought may be distinguished as the inclusive and the distributive. The typical includer is impressed by the power of a great organization to do things the right way and to thwart those whose ideas are erroneous. He wishes to get all organizations in every part of the field under one constitution and one set of officers. He is willing to make concessions, at least temporary concessions, in order to bring in the smaller organizations. He is pained if some smaller groups are reluctant to give up their own organizations and come into the big one. In his mind's eye he sees a great body of united scientists and administrators marching shoulder to shoulder, and always in the right direction. This picture is very attractive. Very little straying off the line of march is contemplated.

The distributive type of mind likes to encourage those who have common interests to gather anywhere that is convenient and compare experience. If a group working on a common project takes a name and elects its own officers, the person of distributive mind has no qualm. He knows that in time issues get settled, the little organization disbands or merges when its work is done, and the very fact of its continued existence—so long as it continues—is indication that there is some job for it to do. He is vastly stimulated by these minor societies to see if the big organization can devise a better scheme to meet a need; he tries one scheme and another and perhaps hits on the very thing that is wanted. But he does not insist that everybody come into the big tent and hunt for a spot in the straw. Our big corporations encourage little ones. To explore for oil or uranium, to operate country telephones, to write local fire insurance, a feeder company may be organized with an officer of the big company in command. Distribution of household gas in tanks was first done by small companies. This Association should welcome feeder societies.

During a war passions are sharpened, and those who have served together are not loath to decry their elders. We were that way after the first World War, too. Out of the war has developed a Group for the Advancement of Psychiatry, who mostly have the background of working in strong, far-spread professional bodies, the Army and Navy Medical Corps. This Group holds meetings twice a year and discusses matters very earnestly. They have committees of their own that correspond and perhaps meet betweentimes. The Group are proud of their committee reports. At their earnest desire and by the votes of their representatives it was decided to print some of those reports in our JOURNAL.

Those of us who are distributively minded welcome the new Group. It includes many of our best minds, and our jobs will soon be done better by those who are 20 years younger than we. We enjoy their enthusiasm and expect great things of them. We urge them not to set up machinery by which their opinion shall be given out as the opinion of the Association. No body of 4,000 physicians has offhand a single opinion on any topic, though it will pretty well agree on some things, after hearing the argument. In the present movement to set up a permanent

medical officer, many have thought of him as primarily the spokesman of the Association. When we find the money to pay the salary and office expenses of a full-time medical man, I sincerely hope that he will not be primarily a publicist, but that he will be an adjunct to the secretary's office and a representative of your Council in keeping active all our professional groups in Canada and the United States.

Our finances are set forth in detail by our treasurer. A few figures call for emphasis and only approximations will be used. We have a surplus of more than $38,000. This has been wisely invested in savings bank accounts and government bonds. The largest increment in one year was $5,000 and lately the average has been $3,000 a year. Last year we had a surplus of $2,200, this year only $484. Even our magazine has made money for two years, $1,000 year before last and almost $1,900 last year. That unprecedented profit is now at an end. This year we shall lose about $800 on the magazine. Other expenses will be higher than formerly. Our rent has been increased about $350 a year. Printing, postage, telephone and other incidental expenses of the office are much heavier than they were, and will not go down. Our payroll has been increased by $1,500, and we hope some day to have room for an additional worker. The office is very crowded and when we get more space it will cost more money. The conversion of the JOURNAL to a monthly will result in additional expenditure, perhaps $5,300. Obviously our finances appear sound but they are not in such condition that broad spending is at all possible. All this will be in your minds when you consider the several plans for extending the work of this Association.

Under good management it has been possible for the Association in the last dozen years to undertake a few new enterprises. In 1946 $5,000 was appropriated to help start the mental hospital survey. More recently we published our biographical volume and a volume on military psychiatry. Last year we shared with the National Committee for Mental Hygiene the cost of a personnel placement service. This year we are developing our publication. Shortly our Committee on Psychiatric Nursing will need an appropriation. These things could not have been done save for the care with which our predecessors handled our finances. The surplus looks so encouraging that some have thought we can spend unlimited sums on any good cause, but this conclusion is not borne out by experience. It is time for decision about the sum we should keep on hand for emergencies.

Our constitution provides that the auditors shall be our Finance Committee. This provision has never been activated. We depend on our able executive assistant to do some budgeting, and to help the executive committee to move wisely between Council meetings. The growth of the Association has led to two new steps this year. First we consulted the auditors about expanding their activity into budgeting, but they are located far apart and perhaps too fixed in number. The Council decided to set up a Budget Committee to help us see how much of our money may be available for our various projects. The other move has been divorce of the offices of secretary and treasurer, which could be done without any change in the constitution. With a separate treasurer and an active Budget Committee we should be able to plan our finance easily and well. Incidentally the intolerable load carried by the secretary has been lightened. I do not see in all this any lessening of responsibility for Mr. Davies and his assistants; in them we have every confidence and on them we shall continue to lean.

The trustees of the Lester N. Hofheimer Estate propose to set up a yearly prize for outstanding contributions to psychiatric research. At their request we are devising a plan for a self-perpetuating board of award. The president will serve on the board, and when board members come to the end of their term of service, the Council will choose their successors from a list of nominations made by the board. The fund will be handled by our treasury. We are happy to have the privilege of administering such a fund, about which you will see more in the JOURNAL. We may be called on to administer another fund in the near future.

So much about associational affairs. Our affairs impinge on much that happens in the community and many results that we seek in

our practice depend even more on community interest and support than on our own efforts. Let us look at some things that are happening around us. Unhappy stories about what befalls our patients in the mental hospitals are only part of the distressing situation of today. In some states, because of lack of beds the old-age patients are not accepted in mental hospitals. Some of them go to jail, some are locked up in almshouses and others are locked up at home. To see this return of ancient abuses is especially disquieting to those of us who thought they were out of date and abolished. Perhaps as Herbert Spencer said in 1868, "We are in course of rebarbarization . . . ."

As regards treatment, a few things may be said. In our hospitals and clinics, treatment still suffers from shortage of personnel and in too many places is on too limited a scale to reach anywhere near the needs of our patients. It is too easy to fall in with the common concept that the mentally ill who come to our hospitals can be pitied but not helped, that little good can be expected from working with them, that meager care is all the situation demands, that time is only wasted if anything elaborate is undertaken. When the proposition is stated thus baldly we resent it, but nevertheless in too many hospitals as well as even in the shade of too many universities, the philosophy of our work is not on a high level, and we find someone saying, "I'm sorry, but you can't do anything for him." Much of this attitude of impatience and hopelessness comes from focusing interest on the psychoneuroses, lack of experience with the psychoses, lack of drill on doing things for our patients.

We cannot be content when so much psychiatric work is in an unhealthy condition. Some of the disorder and deficiency has grown from the inroads of the war years, but other evils existed beforehand and lately have merely been brought into public recognition. We concede the value of routine measures taken for the advantage of a patient in any decent hospital, starting with the benefit of his removal from the environment in which he got sick. In too many places the physician is overburdened and perhaps has come into our work without much training. Too many of our men have not been taught to spend time profitably with the individual patient and therefore are reluctant to do it. Since on the whole we are good organizers, we turn over many medical functions to persons whom we train in ancillary techniques. A telephone operator becomes the admission officer; a supervisor explains the patient's status to him; an attendant gives the first reassurance; the laboratory technician draws and examines his blood; the X-ray technician makes the chest plate and reads it; the dietitian or steward prescribes his food; and so on down the list.

If the new patient is responsive and talkative he is interrogated according to a schedule and his statements are combined into a story that is then known as a history, fixed and embalmed. A social worker or clerk interviews a relative and gets an anamnesis. Neither document is pursued in future studies. When professional men are given this arid fodder it is no wonder that they think treatment consists of sodium amytal, psychoanalysis, electric shock, frontal leucotomy, and little else. Psychoanalysis they have heard is dangerous or inapplicable to hospital patients; leucotomy they would like to learn to do; amytal they may order every night; and everybody gets electric shock unless he has aortic insufficiency. Much as one may regret it, there is too much of this sort of thing.

Being modest, our colleagues sometimes fail to understand how far they might go in giving real treatment, and so they miss some opportunities. They make certain examinations and draw inferences, but have neither the time nor the experience to pry diligently and skilfully into the roots of the patient's trouble and tactfully undermine his hostility and lead him to readjust. Our colleagues who teach need be careful not to let frothy verbiage substitute for hours of solid work with patients, and students should be so well trained that they will not get panicky when called on to examine a patient who does not talk.

Into such a medical atmosphere comes some new scheme, useful when properly applied and in need of further cautious research. Many of us are swept off our feet with enthusiasm. Before my day it was thyroid treatment. Before the first World War

came surgery of the separable organs, including the colon. After the war malaria was administered not only for cerebral lues but for many another ailment. Insulin therapy has been used for all sorts of things but not so widely as its cheaper successor, electric shock, which is administered high and low in hospital and office to an extent that is no credit to us. In sheltered environment, unpleasant occurrences after shock may be very infrequent, but we should caution our colleagues against recklessness. Lately we have called in the brain surgeon as our accomplice, and an operation that makes cheerful invalids out of patients with persistent and apparently irremediable states of mind has been employed also on psychoneurotics and on young people with functional disorders whose outcome we have no right to say is hopeless under other measures of treatment.

Individual psychotherapy should be systematized and expanded in our hospitals. Many members of medical staffs should have their time so arranged that definite periods will be free from interruption. Another physician will receive all telephone calls during the time set aside, and the superintendent will direct that even he will be reminded that this is Dr. Jones' treatment hour. Such an arrangement was made by the late Mortimer W. Raynor. Many patients would be more comfortable if given more physiotherapy. Our mental hospitals can learn much of value by studying what the late Richard H. Hutchings, Jr., brought to pass in three New York hospitals.

Our colleagues in the hospitals are not perfect, as we have admitted, and a considerable number in these days are men who have retired from general practice to enter our field without training. In many cases we have urged them to come in and do something to help. Without joining the general debate, let us remember that most mental hospital physicians among other things become well acquainted with the social problems of their patients, about which we hear so much these days. As has been pointed out by a predecessor in this office, when you tour the wards with a mental hospital staff member he tells you about one patient and another—not only about the patient's ailment but also about his background, his home, his outside problems. As Dr. Russell said, many of these men know more than they think they know. It behooves those of us who are vocal to set right some of the current vagaries that make the situation look even worse than it is. Even in the most isolated hospital the physicians expect to know quickly about the physical ailments of their patients, and when they are well enough to go home. From that level, which implies that the doctor is shepherding several hundred more patients than he should have to, standards go up and up to those of hospitals where any patient can be assured of sympathetic understanding and wise treatment.

Construction of hospital buildings proceeds slowly. I regret that the trend is to further enlarge existing institutions until great sections become mere receptacles. It is not implied that any part of a big institution is necessarily a bad place, but opportunity for personal attention from the ward physician decreases as the institution grows, and more and more wards are lumped together under the supervision of the less experienced doctors. An objection that leads men to steer away from the superintendency of a big hospital is perhaps not mentioned to officials but can be easily elicited. The time-consuming responsibilities of that position prevent the superintendent from knowing many individual patients. The confidence displayed by his patients and their willingness to tell him freely even about private affairs is one of the greatest rewards of medical practice. Many of our colleagues have made a financial sacrifice so as to preserve this relation.

The nursing situation in many of our hospitals has been most distressing. Ingenious schemes have been employed to combat the deficiency. Patients who have recovered or who have not yet recovered have been put on the payroll at some modest figure and given considerable responsibility. In more than one place men were put on duty on women's wards and it is amazing that the complaints received have not been more numerous and bitter than they were. Such men's reputations could be badly smirched by the fantasy of an excited woman patient. Evil indeed is our dearth of nurses. In many places we are worse off now than we were 25 years ago. The trend of nursing educa-

tion has taken our pupils away; there is no use lamenting, for we do not compete successfully with the schools in general hospitals. But here are our patients—a half million in this country and some more in Canada. How shall be provide for them? They cannot wait. Without good psychiatric nursing they must perish in soul, and some in body.

We should probably tread again the steps that our predecessors took decades ago. In 1798 a course of lectures was delivered to the attendants at the New York Hospital. The attending physician started with the employees he had, and set out to improve the fitness of the workers who were already on the job. This was a fundamental project in training. In the 1870's and later, suitable attendants were given courses—mostly lectures—and at the end of about two years were encouraged to take some examinations. If they passed, they were entitled to wear a distinctive uniform and to draw an increase in pay.

At present we cannot make registered nurses of most of our attendants. Educational requirements for admission to nurse training are such that most of the candidates are recent graduates of high schools. We give courses to our attendants, and many of these courses are very practical and informative. So far as the medical lectures are concerned, they are given with the same devotion that characterized the labors of my contemporaries 40 years ago, and are often better lectures than the ones we gave. In my opinion we should do essentially the same things for our attendants that our predecessors did in the eighteen nineties. We should expand the present training course for attendants till it covers about two years, grant diplomas, and above all, follow that diploma with a quick increase in salary. Able nursing instructors stand ready to help in such a movement. Indeed New Jersey reports real progress. The few full three-year schools of nursing that we have should be continued and more if possible established, but to accomplish anything on a broad scale we must turn our eyes in other directions and cease wishful thinking.

The development of the labor movement is of consequence to all of us who are interested in mental hospitals; and indeed who can long be a psychiatrist without a very keen interest in the hospitals? Most hospitals have a union and many have two unions representing the two great labor groups. In New York State there is also an Employees Association, much older than either union and more influential. I am not decrying union activities when I say that their possibilities for good have not been thoroughly explored. Both physicians and union officials have been asked about their point of view and their interest. An important question, "What has the union done to improve the treatment of patients?" has been put to representatives of both groups. I was told in a Canadian institution that the union assumes at times a disciplinary attitude toward a careless member. When this stage is reached a real contribution can be made.

Soon we should resume insisting that fundamentals of decent care be set up in all our hospitals even though really high standards of treatment have to wait till larger staffs are found. Food and clothing, bathing facilities, a measure of privacy—particularly for women—all these topics and more need attention in too many institutions. Take the matter of food, for instance. Little defense can be offered for crudities of preparation and service to thousands of our patients. In many hospitals cooks are never paid enough to hold the good ones. Many institutions have no dietitian and others pay such a small salary that the dietitian who can be hired is not an administrator and must therefore confine her authority to the diet kitchen. The result is that good food is poorly cooked and deadly dull to eat. Dining rooms that should be places of cheerfulness and beauty are too often gloomy, noisy and disorderly spots in an institution that may otherwise be rather cheerful. Would that the tons of battered aluminum dishes that fill the pantries in many of our institutions had been requisitioned by the government for something during the war. Unfortunately the aluminum was not good enough to make airplanes and therefore we still condemn thousands of our fellow citizens to eat off that stuff. Thousands never have a knife or fork. They would use them with propriety but a great state is too poor to buy them—so it is said.

Then of course there are dark murmurs about the misuse of table utensils. Few patients would misuse them, and in the hospitals where they are supplied, they are properly handled.

Among the pleasanter features of our situation today is the participation of the government in the efforts of this Association to develop better mental hospitals. Through the generalship of our colleague, Dr. Treadway, the mental hospital survey was started almost eleven years ago with a supervising committee representing several great bodies, all the committeemen being prominent in this Association. Participation in that continuing survey has been a very great privilege. Since 1939 the U. S. Public Health Service has carried all the financial responsibility and its Mental Hygiene Division the burden of running it. More recently the Division of Tuberculosis Control has equipped many state health departments with the means of making chest surveys in our mental hospitals as elsewhere. And now for more than a year we have had the collaboration of the Division of Hospital Development, which has put an architect on our structural problems. Such a happy state of affairs we yearned for in the National Committee for Mental Hygiene 25 years ago, but Salmon and Williams were not permitted to enjoy it. Rehabilitation is the word used by the federal government to designate a new resource made available to our patients in the states and in some places already used rather well. Not without difficulty did the friends of the mentally ill get the rehabilitation law so written that persons with mental handicaps might become beneficiaries. It is now possible to send our convalescents to a place where they will be advised what kind of training will benefit them; the cost of training is then provided by the rehabilitation agency. The National Committee has embarked on a notable study to develop the most fruitful methods to use in getting such training for our patients. All hospital men will watch that study with deep interest. I shall not discuss the benefits we expect from the National Mental Health Council, for they lie ahead.

My associates, for the honor of presiding over your sessions and sharing the work of your Council, I thank you profoundly. The courtesies shown me during this period have been quite in keeping with the dignity of this office and have moved me more than I would have cared to show. The helpfulness of my seniors and my contemporaries has been matched by the enthusiasm that many juniors have shown in undertaking the tasks to which they have been called. Let us come to united opinions when we can, but even where we divide, let no one forget that his membership is in a fine body of upright and sympathetic professional men and women.

In days when our land is full of talk about less work in return for more pay, it behooves us physicians to set a good example by making more than a fair return for our salaries or our fees—whichever supplies our livelihood. I report to you that hundreds of our colleagues are doing exactly that thing. I meet them not only at conventions but also in the wards of their institutions and in their offices and in other places where they are professionally busy. You have reason to be proud of your profession in these difficult days, and particularly of your associates in the specialty that you have chosen.

Ahead stands our most important goal—better treatment for our patients, and for all patients who are mentally ill. Much of the treatment is done by physicians personally, much by our collaborators in nursing, psychology and other skills, and much through community resources. Whatever plans we make in public or private practice, let us center every scheme on the welfare of some patient. So long as that is our method, we shall not go far astray as individual practitioners, nor as an Association.

SAMUEL W. HAMILTON

President 1946-1947

A Psychiatric Profile

A. A. BRILL

Of the multiform assignments that fell to my lot during my psychiatric career, none was as pleasant as the task before me. When it was suggested that I make a personal sketch of Samuel W. Hamilton as your president, I literally jumped at the idea. For I can now confess that, like many others, I expected and hoped for years to see Hamilton on the Parnassian peak of the A.P.A. It was therefore a source of great satisfaction to me to gather the material for a description of the measure of the man you have chosen as our president for 1946-47.

Hamilton and I graduated from the same medical school in 1903, and as fate would sometimes have it, our paths ran in the same direction since then. We both went into psychiatry as a medical career, we both received our training in the New York State Hospitals, and last but not least, we have not drifted apart as usually happens; on the contrary we have remained close enough now for forty-four years to observe each other's trials and pleasures with friendly and sympathetic eyes. And yet, as you will soon hear, up to the time we were thrown together in the College of Physicians and Surgeons, there were hardly two other classmates who were as far apart by background and environment as Sam Hamilton and Abraham Brill.

When I became aware of Hamilton he impressed me as a quiet, serious and self-possessed individual who like the present writer was too busy for trivialities. Yet Hamilton was quite different from the general run of medical students of his class. I never saw him in Van Glahn's beer saloon which many of us frequented during the lunch hour and on some other occasions. Later I discovered that Hamilton never drank anything alcoholic, never smoked and I never heard him use cuss words. Such singular behavior might ordinarily arouse wonderment, perhaps even some suspicion, but to my knowledge if one ever entertained such thoughts about Hamilton they were soon dispelled by his genial and kindly behavior. Years later when I occupied myself with the problem of "transference" I often thought of Hamilton; I wondered why we were so strongly attached to him who differed from all of us in so many ways.

Hamilton and I belong to a small psychiatric club which has existed since 1914. Hamilton is one of its oldest members, its former secretary and president. At our monthly meetings we dine, drink and discuss lightly all sorts of interesting topics. I am not contradicting myself when I say that *we* dine and drink at our meetings. All of us dine and *drink* but Hamilton invariably sips ginger ale. Yet Hamilton is the seventh president which this club[1] has given The American Psychiatric Association in about a generation. Nor does Hamilton ever participate in the type of witty sallies regularly indulged in by the membership at their meetings, albeit his sense of humor is on a par with the rest of us. He thoroughly appreciates a good joke and thus shows that despite his sedateness, despite his preoccupation with the more serious and broader aspects of life, he nevertheless enjoys some outlets from forbidden sources. It was from observations gleaned during those meetings, where everybody is in the habit of giving free expression to his thoughts, where aided by the spirit of the occasion everybody is "off guard," that I have solved the meaning of our admiration for Hamilton. It is based on an unconscious *feeling of contrast*. It seems that we discern in him a quality which we would fain possess, but which for some reason we either could not or did not as yet attain. This conclusion, I feel, was confirmed by the data that I gathered for this sketch.

Hamilton descended from a hardy Scotch and English stock. He himself traces his lineage to one David Hamilton, a Scot, loyal to the Stuarts who fought against Cromwell, and having been captured was shipped to

[1] The membership of this club is limited to twenty.

Boston with a lot of "Jron Werke" and Scotch prisoners in November 1652 to be bound out as an indentured servant in Newburyport. He did not however remain long a servant. He soon managed to buy land on the shore of the Salmon River in New Hampshire, and then send for his sweetheart Hannah Jackson whom he married and with whom he reared seven sons. When he was quite old and sick he was killed fighting Indians. Your president's great-grandfather, Jonathan Hamilton, was the first physician in the family, and Samuel W. Hamilton adds, "My grandfather and two brothers were homeopathists, also my father and uncle and their cousin. My own cousin and his three sons are physicians."

The maternal side of the family was no less distinguished medically. Roger Tyrrell, free planter of Milford (Connecticut) landed in Boston from England in 1632 and Henry Turrill, our president's maternal grandfather, was a dentist. Dr. Hamilton's father, Warren Henry Hamilton, died at 27 of diphtheria, acquired from the bite of a two-year-old patient whom he was relieving of choking on his diphtheritic membrane. This martyr to his profession was survived by his wife, the former Mary Salome Turrill, and their first and only child of nine months. Samuel W. Hamilton was brought up by his mother in the home of his maternal grandparents, who supported herself and her child by teaching the piano.

I received these notes from our president who ended his letter with the remark: "The Association has no interest in these matters, but I have no doubt some of them confirm your analytic observation of me."

Well, speaking first as a pure descriptive psychiatrist, I was very interested in these notes. For although I have known Hamilton since our medical student days I did not know anything of his early life. The thoughts that flashed through my mind as I read about his lineage ran something like this: "I doubt whether we have ever obtained such a full history of heredity and environment from any former president of this Association." How many of our members can trace their genealogy to the sturdy Scotch-English stock that reached the New England shores at the very beginning of its civilized existence? And how many of our presidents or members, judging by their heredity and environment, can settle the moot question of the transmissibility of acquired characteristics in the manner demonstrated by the life of Samuel W. Hamilton. On his paternal side, beginning with his great-grandfather, there were seven physicians, and as if not to be entirely outdone in the art of relieving suffering, his maternal side added a dentist. In addition, Hamilton's own cousin and his three sons are all physicians. No wonder that Hamilton chose medicine as his vocation. He must have inherited this familial tendency to help mankind.

I must also mention the fact that these physicians were not just ordinary doctors quietly practicing medicine. His great-grandfather was a Thompsonian medico, his grandfather and two great-uncles were homeopathists. One of them was so strongly intent on introducing this form of medicine into the United States that he moved into twenty-four different localities, from one to another, in order to introduce homeopathy. Our president must have inherited this steadfastness to fight for an idea at the hazard of all earthly comforts. For as I have watched Hamilton throughout his medical career I can say that his whole psychiatric mission has been directed to improve the status of the patient in the mental hospital. *Mutatis mutandis* Hamilton like his grand-uncle moved from place to place, from institution to institution in order to find ways and means of improving the lot of the state hospital patient. In his zeal to improve everything that might contribute to the patient's welfare, Sam Hamilton was undoubtedly influenced by his great-grandfather who once said: "I don't cure the patient, I make him more comfortable."

Samuel W. Hamilton was born in Brandon, Vermont. Following his graduation from the Rutland High School, he received his A.B. from the University of Vermont in 1898, and his M.D. from Columbia University (College of Physicians and Surgeons) in 1903. In 1946 his Alma Mater, the University of Vermont, conferred upon him the degree of Sc.D. (*honoris causa*).

Few psychiatrists of the present writer's generation have had as versatile a schooling in nervous and mental diseases as Samuel W.

Hamilton. This can be seen from the following list of his psychiatric activities:

Assistant Physician, Manhattan State Hospital, 1905-1909
Senior Assistant Physician, Utica State Hospital, 1910-1916
Volunteer Assistant, Mental and Nervous Clinic, University of Breslau, 1911-1912
Director, Police Psychopathic Laboratory, New York City, 1917
Psychiatrist in U. S. Army, July 1917–September 1919
Medical Director, Philadelphia Hospital for Mental Diseases, 1920-1922
Assistant Medical Director, Bloomingdale Hospital, 1923-1936
On Staff of The National Committee for Mental Hygiene, as Director of the Division on Hospital Service, 1917-1918, 1920, 1922 to date
Director, Mental Hospital Survey Committee, September 1, 1936, to June 20, 1939
Mental Hospital Advisor, U. S. Public Health Service since September 1, 1936

Dr. Hamilton not only gave faithful service to the positions he filled but he has also recorded his impressions and experiences in numerous papers and addresses. Perusing them—and I read thoroughly many of them—one is impressed by the fact that most of them deal with subjects on the practical aspects of the patient and his environment. Unlike most psychiatric writers who prefer to delve into the theoretical aspects of psychiatry, Dr. Hamilton apparently strove to eliminate the existing deficiencies of the present. His first paper (May 1907) was on treatment of excitement by prolonged baths, and his second paper was on friends of the insane (Philippe Pinel). These two papers were symbolic of Hamilton's position in psychiatry. His mission was to help the patient, and he unconsciously identified himself with the friends of the insane. This is fully confirmed by all his later works too numerous to mention here by title. There are papers on hospital management, on occupational therapy in which, I learned, Hamilton was interested before he went into psychiatry. There are a number of very valuable papers on planning of mental hospitals, on psychiatric service in general hospitals, on the activities of a good mental hospital, on training of attendants in mental hospitals, on the church and the mental hospital, the problem of military rejects and casualties, etc.

These titles were selected at random from a long list to show Dr. Hamilton's devotion to the cause of the mental patient. All his papers can be read with profit by any person interested in the alleviation of suffering; his "History of American Mental Hospitals" in One Hundred Years of American Psychiatry [2] is a veritable treasure of information which no student of psychiatry should fail to read.

Before I knew anything about his early life I, a Jew, often looked at Sam and said to myself, "Here is a real modern Christian, conscientious, steadfast, philanthropic and unostentatious." I was surprised to hear that Dr. Samuel W. Hamilton was an *only child*, concerning which I have long ago said many things in a paper published in 1912. My main thesis was that the only child is as a rule maladjusted to life. I am very glad that I said also that there are exceptions if the child is properly reared. This was the case with Sam Hamilton. His mother, I was told by our president's wife, was a very magnetic and charming person who following the death of her husband devoted her whole existence to the nurture and education of her son. She evidently sensed that a boy needed the guidance of a father and she therefore enlisted the office of her pastor, Dr. Reese, a Baptist minister, who was a great influence in Hamilton's life. The school of psychoanalytic psychiatry I represent teaches that everything being equal, a man is guided in the selection of his wife by his mother-image. In choosing the charming Ruth Norton Hamilton as his life's mate Hamilton has continued under the same patient and benign care as he was under his own mother. There were two children: the daughter, Eva, died five years ago, and their son William is a forester.

This in brief gives, as it were, a profile of your president for 1946-47. It also explains, why Sam W. Hamilton chose the profession of medicine, why after he went into psychiatry because he was in debt and wanted to pay it, decided to remain there, for no other vocation offered a better *vis a tergo* for his particular personality, and why the State of New Jersey is to be congratulated on having acquired his services as Superintendent of the Essex County Hospital for the Insane.

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[2] The American Psychiatric Association (Columbia University Press 1944).

THE PLACE OF PSYCHIATRY IN THE VETERANS ADMINISTRATION MEDICAL PROGRAM [1]

MAJ. GEN. PAUL R. HAWLEY, M.D., WASHINGTON, D. C.

I should like to give you a general summary, a sort of aerial photograph of the neuropsychiatric problems facing the Veterans Administration, and to touch briefly upon some of the solutions we are evolving for them. Most of these matters have been discussed in more detail by other speakers so I shall devote but a word to each phase of the situation.

First, let me call your attention to the size of our job. Our armed strength during the first World War was roughly 4½ million, and from this group almost 70,000 neuropsychiatric disabilities resulted. We created what then appeared to be a mammoth hospitalization program for veteran care, and by 1945 had in all over 90 functioning hospitals, 32 of which were for neuropsychiatric patients. It is sobering to learn that some 50,000 neuropsychiatric beds were necessary to meet these needs.

During the war but recently over, 13 instead of 4 million men and women went into uniform. We are informed from the medical departments of the various armed services that well over 600,000 individuals have already been separated for neuropsychiatric disorders, or for defects of character or personality which prevented their retention in service. I am sure all of us here today, with the exception of the few visiting astronomers [2] who may be in our midst, feel a sense of unreality about figures of this magnitude. Perhaps it would be simpler to say that, great as the problem was following the first World War, it is at least three times greater today, three times tougher, and, I might add, three times more pressing in its immediacy. There are far different social and economic influences at play in our civilization today than in the twenties, a far different tempo in world events. We have got to find solutions and we have got to find them now.

I said a moment ago that some 50,000 beds were found necessary to care for the neuropsychiatric invalids from the first World War and from previous conflicts. Does this mean that 20 years from today we are to have 400,000 neuropsychiatric beds, a hospital at every crossroads, a staff of Veterans Administration employees that could populate one of our larger cities, a budget appropriation that would resemble our national debt? It could, if we follow the pattern of the past. It could mean all of these things. The medical profession as a whole, and more particularly the psychiatrists and the neurologists of our country, have never before been so directly challenged. Here and today we are being put to the test. Is there such a thing as preventive medicine? Can a psychiatric illness be recognized soon enough, and treated effectively enough, to prevent the patient's withdrawal from society even for a short period? Can the course of existing psychiatric disorders be modified? Can the psychiatric invalid be restored to a level of social adjustment that makes community functioning possible?

Society is asking these questions. I am convinced that the psychiatrists of the United States can answer them. I am consciously and intentionally passing this question and this challenge along to you. The time has passed when such an agency as the Veterans Administration can be something apart, a thing unto itself. The time has passed for jealous guarding of the narrow prerogatives of any clique. My sons as well as yours are now "veterans." The sons of my neighbors as well as of yours are now "veterans." As fathers, and as men, we cannot "leave it to George" with flesh of our flesh and bone of our bone. We cannot as physicians ignore our duty.

The Veterans Administration cannot do this job. I say this in all frankness and in all candor. The Veterans Administration

[1] Maj. Gen. Hawley was a guest speaker at the 102nd annual meeting of The American Psychiatric Association, Chicago, Ill., Mar. 27-30, 1946.

[2] Dr. Harlow Shapley was also a guest speaker at this meeting.

cannot do the job alone. It is a task that will tax the strength, the skill, and the patience of every qualified physician in the country. It is a job which requires—which demands—the combined effort of the entire medical profession, no whit less than did the tremendous medical programs of the armed forces during the war. It can be done only when we have each become "physician to the American veteran" just as we were "physician to the American soldier" only a few months ago.

I promised to mention briefly some of the solutions that are being evolved. They were developed with your help and under your direction. I see many physicians here today who have sat on our consultative and advisory boards in Washington. Implementation of the ideas evolved there was possible only with your help, and their effectiveness will, in a major way, be the reflection of your continued, unstinted efforts individually, and through such organizations as The American Psychiatric Association, toward our common goal. Outstanding men in the various specialties already are giving us the benefit of their wisdom and their experience on the spot from Maine to Texas, and from Washington to Florida. We are determined to expand this program until we have a group of medical consultants representing every major specialty working in direct conjunction with each of our 13 branch offices. We must have your help and the help of your association. Nor will this be sufficient. Each of our hospitals must rely upon the most skilled of the physicians in its immediate community for guidance and for direct professional advice. Again The American Psychiatric Association can be of invaluable help in assuring us highly qualified men for these posts.

Hospitals—we shall of course need more. Those now in existence are, almost without exception, overcrowded, and their facilities far below what you and I consider ideal. We have enough asylums scattered over the country, some under Federal operation, some under that of the States. We want, we need, and *we will have,* hospitals worthy of the name. You have suggested that general hospitals have active psychiatric services; that psychiatric hospitals have active medical and surgical departments. You have suggested that these be located in proximity to medical schools, to centers of population, to the best medical skills in the community. This will be done. We have now in Washington a group of architects from New York City, from Chicago, from the West—the best we could find—who, as I talk, are designing these hospitals to meet the most up-to-date requirements of not one, but of every medical specialty. It is my conviction that our new hospitals will meet and excel the most advanced construction standards in the world.

The neuropsychiatric division of our general hospitals and our psychiatric hospitals will be structurally designed for treatment. Occupational therapy wings, with lathes, photographic laboratories, carpenter shops; shock therapy suites; extensive hydrotherapy departments; neurosis centers—all will shorten hospitalization and improve our results.

I am told and I believe that there are few illnesses which do not carry with them psychiatric implications. I am told that this is especially true in the chronic debilitating disorders and in those mutilating conditions which seem naturally the province of the surgeon and the orthopedist. A number of our psychiatric hospitals are being designated as tuberculosis centers. In an atmosphere peculiarly oriented to the personal needs of the individual, these patients will receive the benefit of every modern therapy administered either by psychiatrists skilled in the treatment of tuberculosis, or tuberculosis men skilled in psychiatry, wherever you choose to place the accent.

Our Medical Rehabilitation Division, working in intimate collaboration with psychiatry, will assist the disfigured patient, the amputee, the blind, to come to terms with his handicap, physically and emotionally.

Through the establishment of active psychiatric units in our general hospitals our cardiologists and our allergists will have the services of the psychiatrist immediately available. Our psychiatrists will have constant access to the particular skills of the internist and of the surgeon. Our patients will at last receive the care implicit in the name "general" hospital.

You have stressed the need for treatment of that large group of patients whose disorders do not warrant hospitalization, but who are still too disabled to take their rightful place in the social structure. You have talked in terms of outpatient therapy, of mental hygene clinics, and of social service work in the community. Until very recently all psychiatric outpatient departments of the Veterans Administration served a dual purpose. Pension examinations were performed in an effort to determine the patient's percentage disability, and at the same time attempts were made by the same physician, and frequently during the same interview, to treat the patient's illness. We are rapidly correcting this manifestly undesirable situation through the establishment of clinics staffed by psychiatrists, social workers, and psychologists, whose function will be entirely that of therapy. It will be possible for the eligible patient to come to these clinics by referral from other departments of the Veterans Administration, from community agencies, from private physicians, or simply on the basis of his own desire for help. There will be no pension examinations performed here.

Where it is not feasible for the Veterans Administration to establish such a clinic, where special therapeutic techniques are available in the outpatient department of the community hospital, and more particularly in those dense areas of population, where no one clinic, regardless of its size, could hope to serve all the patients needing assistance, again we must rely on you in the community to provide this care for your veterans. Many such contract clinics are already operating; more will be needed.

There is, we believe, no substitute for the intimate therapeutic relationship of the private physician and his patient. The medical societies of many of our states are rapidly working out plans whereby qualified specialists in neurology and psychiatry may apply their skill to the problems of the veteran patient. In some states these plans are already in operation. We need them in all.

The finest plans are sterile without human beings to put them into operation. The finest hospital in the world, the finest outpatient department in the country will be an empty architectural achievement until it is staffed. There have been too few doctors, too few nurses, too few social workers, too few psychologists, too few attendants, too few physical therapists, too few—I shall not continue to name every category of worker devoted to the care of the neurological or psychiatric invalid. There have been too few of all. There are too few today. None of us in the medical profession will settle for numbers alone; we must also have quality. Our need for competent well-trained men and women in every medical branch has not been met. Here again is a job that is the responsibility of the whole medical profession. You have made magnificent efforts in this direction already. We must continue them. Resident training programs are being set up through your various deans' committees and professors of psychiatry in a number of veterans hospitals. None of us will be satisfied until every hospital comes under such sponsorship. Our staff physicians need and want these stimulating contacts. Young physicians just completing their internships, and older men looking for intensive training in a specialty, need and want the best educational program that can be established. The patients need and deserve the finest medical care available in the country.

Our hospitals are affiliating with nursing schools, and cadet nurses already are being trained in several localities. Other programs of affiliation are being developed with schools of social work. We are expanding our courses for hospital attendants, and making it possible for physical therapists, educational advisors, occupational therapists, and medical workers of every category to perfect their techniques and advance their skills both in veterans hospitals and in community centers. All of these programs, from the establishment of residencies, to weekly meetings between a ward physician and his attendants, will be reflected in progressive improvement in patient care, in shortened hospitalization, and in more rapid integration of discharged patients into community life.

All of us have a task before us which is not small. We can ignore the health of 13 million men and women, the finest of our country's youth, at our peril and at the peril of the future of the world. There is today a

uniformity of purpose and a determination to meet our obligations to the veteran, that permeates every stratum of society. The standards of the American medical profession, the knowledge and the skill of the country's physicians, and the material resources at their command, are unequaled. As men, as fathers, and as doctors, we must hold to this strong purpose. We must duplicate, and duplicate again, these professional skills. We must help our young men and our young women, back once more from war, to meet the future with all that we can give them—strong bodies and sound minds.

SEDIMENTATION RATE AND WHITE BLOOD COUNT IN MENTAL PATIENTS WITH RHEUMATIC BRAIN DISEASE[1]

WALTER L. BRUETSCH, M. D., INDIANAPOLIS, IND.

The *Annals of Internal Medicine* (21: 494, 1944) in an editorial discussing "The Cerebral Vascular Lesions in Rheumatic Fever," as they occur in mental patients with rheumatic brain disease(1-7), requested more information particularly with regard to fever, sedimentation rate and white blood count.

As to fever it may be stated that there is usually no elevation of temperature in mental patients with rheumatic encephalopathy. However, if in such patients a four-hourly temperature chart is kept over many weeks, there will be periods during which the oral temperature may reach 100° F. Other conditions such as incidental upper respiratory infections or latent pulmonary tuberculosis, which may produce such low grade fever, were carefully excluded.

Concerning the sedimentation rate and the white blood count two questions will be answered with this study: (1) Are there an accelerated sedimentation rate and increased white count in patients with chronic rheumatic brain disease, and (2) Are the determination of the sedimentation rate and of the white blood count of diagnostic value in differentiating patients with rheumatic encephalopathy from patients afflicted with other types of mental illness?

FREQUENCY OF AN INCREASED SEDIMENTATION RATE IN MENTAL PATIENTS WITH RHEUMATIC BRAIN DISEASE

The study consisted of 28 mental patients with rheumatic brain disease in whom the sedimentation rate was determined. All the patients had concomitant rheumatic heart disease. There were available from two to five determinations of the velocity rate of the erythrocytes in every patient. The Cutler vein method was used for determining the sedimentation rate(8, 9).

Of the 28 cases, 85.7 percent had an increased sedimentation rate. Of these, 15 cases (or 53.6 percent) had a slightly increased velocity rate, ranging between 10 to 19; and 9 patients (or 32.1 percent) had a moderately increased sedimentation rate of 20 to 30.

FREQUENCY OF AN ELEVATED WHITE BLOOD COUNT IN MENTAL PATIENTS WITH RHEUMATIC BRAIN DISEASE

In 40 patients with rheumatic encephalopathy, associated with rheumatic heart disease, from two to eleven examinations of the white blood count were carried out.

The question arose as to what should be regarded a normal white count. Ten thousand white cells were considered the upper limit of normal in this study, although most hematologists consider 8,000 to 9,000 as the upper limit of normalcy. Ernstene(18) regards all counts below 9,000 cells per cmm. as normal in patients with former acute rheumatic fever.

Of the 40 patients, diagnosed psychoses with rheumatic brain disease, 30 percent had at one time or other a white blood count over 10,000. Of these, 17.5 percent had a white count ranging between 10,000 and 12,000; and 12.5 percent had a white cell count between 12,000 and 15,000. There were no cases with a leukocytosis over 15,000.

The simultaneous measurements of the sedimentation rate and of the leukocyte count reiterated the already known fact that the sedimentation rate is a more sensitive criterion of activity of the infection in rheumatic fever than the leukocyte count. This is illustrated by the following example.

The female patient, at the age of 22, was informed that she had a heart murmur. When 35 years old she was in bed for five months with "rheumatism." This illness was interpreted as a recurrence of

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rheumatic fever. Eighteen years later, then aged 53, she had a stroke, which left a residual monoplegia and hypalgesia of the left arm. At the same time mental symptoms made their appearance. She became destructive, tearing pictures from the wall, and threatened to kill her neighbors. On various occasions she left the house unclad.

When admitted to the Central State Hospital, there were days when she had an unexplained oral temperature of 99½° to 100° F. The pulse was slightly irregular, and the rate was 100 per minute. The blood pressure was 150 systolic and 90 diastolic. There were no joint pains. A systolic and diastolic murmur was heard over the aortic region. The roentgenogram showed cardiac enlargement, and the electrocardiogram revealed evidence of myocardial damage. The diagnoses were as follows: psychosis with rheumatic brain disease; subclinical rheumatic fever; rheumatic aortic stenosis and insufficiency.

From 1940 to 1946 simultaneous determinations of the sedimentation rate and of the leukocyte count were made at regular intervals. During this time the sedimentation rate oscillated between 13 and 20 (10 is normal), while the white blood count remained well within normal limits, ranging from 4,750 to 8,300. In the differential count, however, there was at all times a marked shift to the left, with band forms averaging from 6-14 percent (normal 4), juveniles from 2-8 percent (normal 0), and myelocytes from 2-9 percent (normal 0).

On a rare occasion the reverse observation may be made, namely, there is an increased white count and at the same time an almost normal sedimentation rate. Wilson(10) in an analysis of the case records of 34 consecutive admissions to the Children's Pavilion of the New York Hospital observed 7 subjects with clinical symptoms of rheumatic activity, having a normal sedimentation rate in the presence of an increased leukocyte count. The following case history exemplifies such an instance.

The female patient, with a history of Sydenham's chorea at the age of 8 and 14 years, developed, when 31 years old, psychotic manifestations of the dementia præcox type. There was rheumatic mitral stenosis, which was well compensated. The pulse rate was 85. At one time, when the patient was mentally much improved, there was a white blood count of 14,800 and a sedimentation rate of 11 (10 is normal). The temperature at this moment was 97° F.

The Differential Diagnostic Value of the White Blood Count and of the Sedimentation Rate

The second question as to the value of the white blood count and of the sedimentation rate in the differential diagnosis of patients with rheumatic brain disease from other mental cases is more difficult to answer, because an accelerated velocity rate and leukocytosis occur in a variety of psychotic patients. Bowman(11), who made a statistical study of the white cell count of patients on admission to the Boston Psychopathic Hospital, found the leukocyte count over 10,000 in 54 percent of the schizophrenic cases and in 53 percent of patients with manic-depressive psychosis. Diethelm and his associates(12) in a series of 200 patients, representing consecutive admissions with "various emotional states," to the Payne Whitney Clinic in New York found that approximately one-third of the patients had initial white blood counts of 10,000 cells or over. In 34 patients of this group, however, some infectious condition was present such as sinusitis, rhinitis, pyelitis, pelvic inflammatory disease, and pulmonary tuberculosis which influenced the leukocyte count. In Diethelm's study(12) rheumatic heart disease was not mentioned among the possible chronic infections. My own studies on the leukocyte count of various diagnostic groups of mental patients revealed a considerably lower percentage of white cell counts over 10,000. In newly admitted schizophrenic patients 20 percent, and in patients with manic-depressive psychosis 21 percent, had a white blood count over 10,000.

In another of my blood count studies of new admissions, comprising every type of psychosis, the white cell count was over 10,000 in 22 percent. This compares with 30 percent in mental patients with rheumatic brain disease. From a statistical comparison of these figures it is obvious that the determination of the leukocyte count is of little aid in ferreting out patients with rheumatic brain disease from other types of mental illness, among which they may be hiding. Neither is Schilling's differential count of much value because a shift of the neutrophilic blood picture to the left has been frequent in all types of major psychoses of my case material.

Strikingly, in the rheumatic mental patients there were no white cell counts over 15,000 cells, while in the schizophrenic and manic-depressive patients of Bowman(11)

there were 11 and 12 percent respectively. In my own material 6.6 percent of schizophrenic patients had on admission a white cell count over 15,000. Some of the patients admitted to the Payne Whitney Clinic(12) had leukocyte counts as high as 18,000. The behavior associated with leukocytosis was given as panic reaction, depression with agitation, excitement with overactivity and elation. The white cell count in these cases returned to normal levels when the fear subsided. Diethelm and his co-workers(12) expressed the opinion that the leukocytosis could not be explained solely by the emotional factor, because there were cases with pronounced anxiety in which a persistent low white count was present. With this conclusion I concur.

The question then arises: Is the more sensitive sedimentation test of some diagnostic aid in this problem? Many sedimentation studies in mental patients have been carried out. Only a few will be mentioned here. Stephenson(13), who studied the sedimentation rates in various psychoses, found in patients with senile and arteriosclerotic psychoses the rates increased in 78 percent. In 150 schizophrenic patients with no apparent physical illness or infection 60 percent had elevated rates of sedimentation. Schottky (14) reported normal values in cases of schizophrenia even if they showed a tendency to progression. In catatonic excitement, however, the sedimentation rate was always accelerated. In manic-depressive patients Schottky(14) observed normal values. Freeman(15) studied 47 cases of schizophrenia and came to the conclusion that neither the catatonic nor the other types of schizophrenia showed the abnormal values so frequently ascribed to them. It is obvious, then, that at this stage of uncertainty as to the exact status of the velocity rate of the erythrocytes in mental diseases, the sedimentation rate is of no clear-cut value in this particular question.

Histologic Correlation Between the Sedimentation Rate and the Activity of the Rheumatic Process on the Heart Valves and in the Cerebral Vessels

For this part of the study 4 cases with rheumatic brain disease were available. In all four instances a most extensive histologic examination of the brain, heart, and remaining organs was possible. In the following, one of these cases will be described in detail. In the other 3 only summary findings will be reported.

Case 1.—*History.*—B. G. N., a female patient and former school teacher, at the age of 58, developed rather suddenly an abnormal behavior, which necessitated commitment to an institution. She was the mother of 3 children. Until the onset of the psychosis she had been considered a strong-willed but otherwise well adjusted person. Quite abruptly she became unreasonable and suspicious and threatened the life of members of her family. At other times she secluded herself in a room.

On admission to the Central State Hospital, a harsh, systolic blow was heard, which was loudest in the second right intercostal space (aortic area), but which was also present in the mitral and apical region. There was a systolic thrill at the base of the heart. The pulse was 90 per minute. Its volume was small. On exertion, pulsation of the jugular vessels became noticeable. The blood pressure was 90 systolic and 70 diastolic. The roentgenogram revealed cardiac enlargement, mostly confined to the left side of the heart. The electrocardiogram was within the limits of normal. (It is not uncommon to have a normal electrocardiogram in the presence of organic heart disease.) A diagnosis of aortic and mitral disease, very likely on a rheumatic basis, was made, although a positive history of a previous rheumatic infection could not be elicited. At no time was there any evidence of cardiac decompensation.

The pupillary reactions were within normal limits, and the patellar reflexes were present.

Mentally, the patient presented the picture of an early senile psychosis with a paranoid trend. After a few weeks the mental symptoms subsided, and she was sent home. Six weeks later she became again disturbed and was returned to the hospital in a state of overactivity and talkativeness. She believed she was unduly held in the hospital and expressed ideas of persecution in reference to her sons. The memory was good for present and past events.

After a period of seven months practically all the symptoms disappeared, and she returned to her family. For six years she led a fairly well adjusted life, when she again became talkative and renewed her paranoidal activities. The acute behavior disturbance disappeared again, but this time she remained in the institution until she died two years later at the age of 73 of a pulmonary infarct.

In the last months of her life her memory was still fairly good. She was able to make a simple conversation very much like that of a person of her age and social standing.

The Wassermann reaction of the blood and spinal fluid was negative on three occasions. The cell count, total protein, and the colloidal gold curve of the spinal fluid were normal. In the urine were a slight trace of albumin and an occasional granular cast.

FIG. 1.—Rheumatic disease of aortic valve of many years' duration. On the aortic cusps are calcified coarse vegetations. Below is a normal aortic valve for comparison.

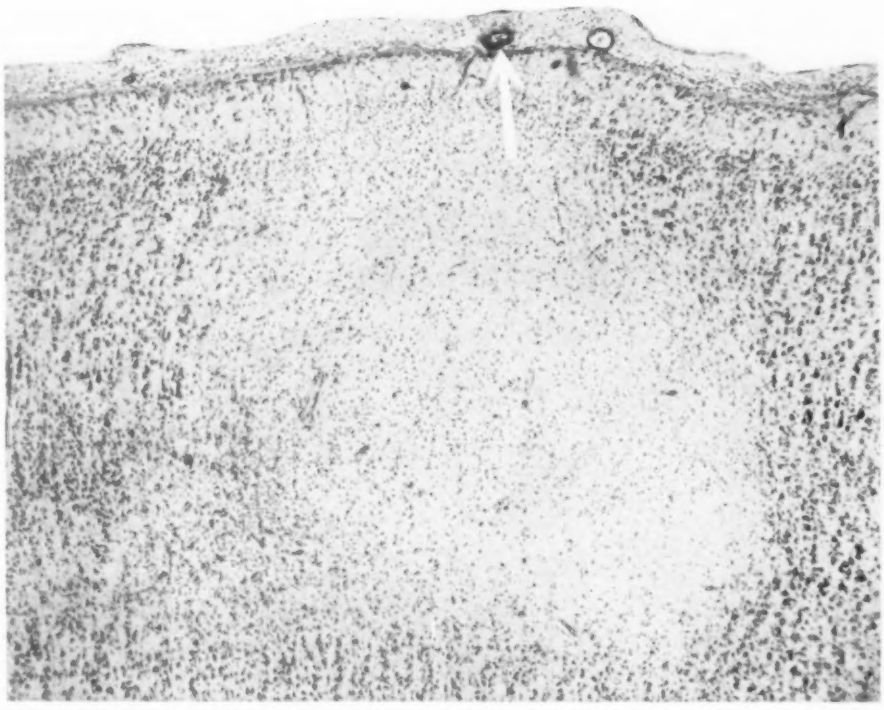

FIG. 2.—Rheumatic brain disease. Area of incomplete softening (acellular area) in cerebral cortex. One of the two small meningeal vessels, which on this section shows only beginning obliteration (arrow), is completely occluded in succeeding sections. Toluidin blue stain.

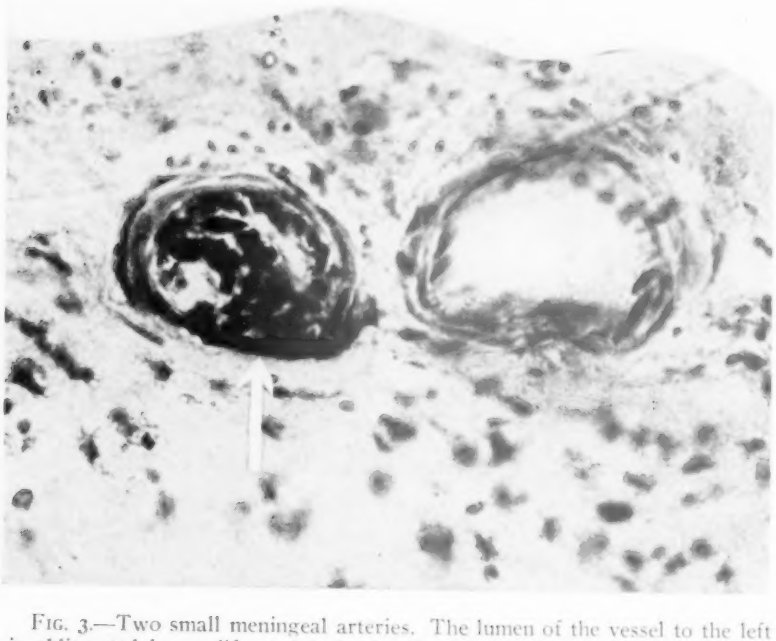

FIG. 3.—Two small meningeal arteries. The lumen of the vessel to the left is obliterated by proliferated intimal cells (rheumatic endarteritis of intermediate age).

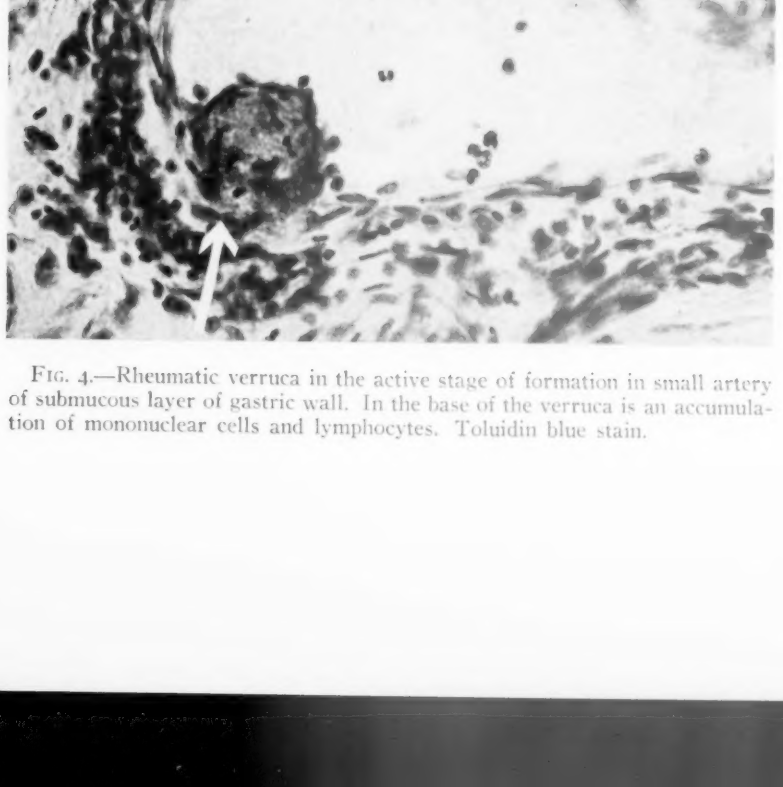

FIG. 4.—Rheumatic verruca in the active stage of formation in small artery of submucous layer of gastric wall. In the base of the verruca is an accumulation of mononuclear cells and lymphocytes. Toluidin blue stain.

In the two years prior to her death the sedimentation rate was moderately accelerated, *i.e.*, the rate stayed between 24 and 27. The white blood count was never higher than 8,500 with 10 percent band forms and 4 percent myelocytes.

The diagnoses were: psychosis with rheumatic brain disease; subclinical rheumatic fever; rheumatic aortic stenosis and mitral insufficiency.

Postmortem Observations.—Autopsy confirmed the clinical diagnosis of chronic rheumatic disease of the aortic and mitral valves (aortic stenosis and mitral insufficiency). The mitral valve ring was calcified in its entire circumference. On the inner and outer surface of the three aortic cusps were numerous calcified nodules (Fig. 1). The aortic valve had lost entirely its elasticity. In the past the gross appearance of such an aortic valve in an elderly individual would have suggested an arteriosclerotic etiology. Due to a better understanding of the pathologic findings in rheumatism, such valves are now considered the result of rheumatic fever(16). In addition, there was pericarditis sicca. The heart was enlarged, weighing 460 gms.

Other gross findings were a recent hemorrhagic infarct in the left lower lobe of the lungs and passive congestion of the liver.

Under the microscope both the mitral and aortic valves divulged rheumatic activity. In particular, in the aortic cusps were foci consisting of large macrophage-like cells with basophilic cytoplasm having assumed the morphology of Aschoff cells. There were also large plasma cells, some with two nuclei, and lymphocytes. In one out of eight myocardial tissue blocks one small Aschoff body was observed. The Aschoff nodule consisted of about twenty mononuclear cells, one of these being in the stage of amitotic cell division, and of an equal number of lymphocytes. This nodule would possibly have escaped notice, if pieces of the heart muscle had not been fixed in alcohol and stained with toluidin blue. This technique is the same as the Nissl method, used for the staining of the brain. It intensifies the basophilic properties of the cytoplasm of the Aschoff cells, which then can be picked out with relative ease. In addition to the isolated Aschoff body, individual Aschoff cells were scattered here and there in the interstitium of the heart muscle. In eight myocardial tissue blocks twice vessels were observed with recent endarteritis, the proliferating intimal cells attracting attention on account of the reddish cytoplasm. Occasionally, the lumen of some of the vessels was compressed by an increased amount of old connective tissue about the vessels. This is considered by Klinge(17) a characteristic feature of a rheumatic heart muscle.

In the adventitia of the aorta one Aschoff body was found. The loose connective tissue of the entire adventitia appeared to be in a stage of activation, as evidenced by the light-red cytoplasm of the connective tissue cells. There were also several thick-walled rheumatic-endarteritic vessels in the adventitia.

The brain was grossly normal. There was little if any atrophy of the convolutions. The vessels at the base as well as the meningeal vessels were entirely free of yellow atherosclerotic plaques. Microscopic examination revealed rheumatic brain disease. There were areas of incomplete softening (acellular areas) in a little more than half of the tissue blocks, which were removed from the upper aspect of the brain (Fig. 2). The acellular areas were much less frequent in cortical blocks from the lateral aspect and from the temporal and orbital lobes. In the latter regions only one acellular area was observed in about every tenth tissue block. There were small meningeal (Fig. 3) and cortical vessels with rheumatic endarteritis. On serial sections it was observed that the rheumatic-endarteritic occlusion of Fig. 3 extended over only a short distance. Then the vessel was entirely free of intimal proliferation. Some of the changes on the cerebral vessels were of intermediate age, but others were recent and active at the time of death. For instance, in one meningeal artery with an active endarteritic process, proliferating intimal cells were seen growing toward the center of the lumen, entangling white and red blood cells. Once a small connective tissue scar was noted in the middle cortical layers of the frontal lobes. As to the number of intravascular leukocytes one may say that, generally speaking, there were few white cells in the lumen of the cerebral vessels. The basal ganglia and other portions of the brain were free of changes.

In the muscular layer of several large arteries of the spleen a few small Aschoff bodies were present. There were no rheumatic-endarteritic vessels..

In the liver was passive congestion. The histiocytic lining cells of the capillaries revealed no evidence of stimulation, and immature white blood cells were not present in the lumen of the liver capillaries.

With the exception of an increased number of mature polymorphonuclear leukocytes nothing unusual was observed in the bone marrow.

In the submucous layer of the gastric wall a thin-walled artery with a delicate rheumatic verruca was present, consisting of actively proliferating intimal cells (Fig. 4). On one of these cells a mitotic figure was encountered. In the base of the verrucous formation there was an accumulation of mononuclear cells and lymphocytes. In cutting the vessel serially, the verruca was present in eight sections only, then disappeared completely, leaving an entirely normal intima.

Comment.—In this patient with no outward symptoms of rheumatic fever there were moderately increased sedimentation rates with normal white blood counts in the two years prior to death. The clinical diagnoses of rheumatic brain and heart disease and subclinical rheumatic fever were verified by histologic examination, bringing to light old and recent rheumatic changes in the brain and activity in the tissue of the heart valves. Aschoff bodies in the myocardium, in the adventitia of the aorta, and in the muscular layer of splenic vessels

were evidence of the presence of subclinical rheumatic fever. An intimal verruca in a vessel of an abdominal organ was observed in the active stage of formation, presenting further proof that the rheumatic infection in this individual was still or again active, although the initial infection must have taken place many years ago.

CASE 2.—O. T., male, aged 60. Psychosis with rheumatic brain disease and subclinical rheumatic fever, presenting the mental picture of a pre-senile psychosis. There was rheumatic aortic stenosis. Six months prior to death, when the patient was otherwise in good physical health, the sedimentation rate was 22, and the white blood count was 10,550 cells.

Postmortem Observations.—On the aortic cusps, which were studded with large roughened nodules and calcified vegetations, there was recent activity as shown by microscopic examination. In the tissue of the aortic valve were areas with large numbers of lymphocytes, plasma cells, macrophages laden with yellow pigment, and multinucleated Aschoff cells, some of the latter having assumed the characteristics of giant cells with 6 to 8 to 10 nuclei. Along the closing border was a narrow rim of fibrin into which young fibroblasts were growing. In the mitral valve were only slight quiescent rheumatic lesions consisting of obliterated blood vessels. In the myocardium an occasional Aschoff body with large basophilic cells in the stage of mitotic cell division pointed toward activity of the rheumatic process.

There was rheumatic encephalopathy with a moderate number of areas of incomplete softening (acellular areas) in the cortex. In the brain, recent activity of the rheumatic process was manifested by the presence of a small meningeal artery with a proliferating intimal cell in the stage of amitotic cell division.

In the spleen, several blood vessels were obliterated by old acellular connective tissue. In other splenic vessels were actively proliferating endothelial cells. In one instance the intimal proliferation took place adjacent to a small area of fibrin, which was lying against the vessel wall.

CASE 3.—T. G., female, aged 47. Psychosis with rheumatic brain disease and subclinical rheumatic fever, with the symptomatology of rheumatic epilepsy(3). The cardiac diagnosis was rheumatic mitral insufficiency. On the last re-admission, the sedimentation rate was 13 and the white blood count was 9,300. Three months before her death, in the absence of any physical illness, the sedimentation rate had accelerated to 22 and the white blood count had increased to 13,100.

Postmortem Observations.—There was chronic rheumatic valvulitis of the mitral valve with histologic signs of recent activity. Along the closing border were areas with young fibroblasts. A few polymorphonuclear leukocytes were intermingled with these cells. In these regions small amounts of fibrin were noted. In other areas of the mitral valve, lymphocytes were scattered in a loose fashion throughout the valvular tissue. Deep in the tissue of the mitral valve a group of large basophilic mononuclear cells was observed, which was interpreted as an Aschoff body. In the heart muscle an occasional Aschoff nodule, some of these being in the stage of regression, were found in approximately one half of the tissue blocks. There were several myocardial vessels with old and one with fairly recent endarteritis.

There was chronic rheumatic brain disease with old endarteritic changes of the small cortical and meningeal vessels. The obliterated small vessels had produced numerous areas of incomplete softening (acellular areas) in the grey matter. There was no evidence of recent rheumatic vascular disease in the brain. In the lumen of the vessels of the brain and internal organs the number of white cells was about normal.

CASE 4.—T. O., male, aged 46 years at the onset of the psychosis. Death at age of 86. Psychosis with rheumatic brain disease and subclinical rheumatic fever. During forty years the patient had periodic psychotic attacks during which he was suspicious, threatening and depressed. At times he refused food for fear of being poisoned. In spite of this severe maladjustment he was able to live most of the time outside of an institution. Six months prior to death, while he was in good physical health, the sedimentation rate was 28 and the white blood count was 6,200.

Postmortem Observations.—On the mitral valve were old fibrosed vegetations and signs of mild recent activity with fibrin along the closing border which was in the stage of organization by young fibroblasts. In two out of thirteen myocardial blocks there were rudimentary Aschoff nodules, consisting of 8 to 10 and more Aschoff cells. In the pericardium was slight lymphocytic infiltration.

In the brain was rheumatic disease with acellular areas (incomplete infarctions) and rheumatic obliterating endarteritis of small meningeal vessels of many years' duration. There was no recent rheumatic activity in the cerebral vessels. In the kidneys a mitotic figure on a proliferating intimal cell of a small artery was observed.

DISCUSSION

The correlation of increased sedimentation rates with histologic studies in 4 patients with rheumatic brain and heart disease disclosed rheumatic activity on the heart valves and sometimes in the vessels of the brain and of other organs in every one of these patients. The sedimentation rate in these individuals had shown a slightly or moderately increased acceleration of the erythrocytes. On the other hand, the white blood count which was studied simultaneously had, with one exception, remained below

10,000 white cells. From the results of this study one can conclude that the sedimentation rate in mental patients with rheumatic brain disease is a sensitive index of activity of the rheumatic infection. Rheumatic fever cannot be considered extinguished until the sedimentation index has returned to and remained normal. However, one should always keep in mind that occasionally rheumatic fever may be active in the presence of a normal sedimentation rate(10).

Of the three indices of activity: fever, leukocytosis, and sedimentation rate, fever is possibly the least reliable guide as patients with active infection may have normal temperature. The same may be said of the leukocyte count(18, 19). Ernstene(18) observed during the acute phase of rheumatic fever the leukocyte count to return to a level below 9,000 within a few days to two weeks after the subsidence of fever and polyarthritis. At that time the infection is obviously still present, yet the leukocyte count has already ceased to be an index of activity. It should be pointed out here that even during the active polyarthritic phase of rheumatic fever the leukocytosis is usually not very high, ranging as an average from 13,000 to 17,000. The sedimentation test, on the other hand, is of definite value in detecting the presence of active rheumatic fever, which otherwise might escape notice, in individuals who show no outward signs of rheumatic fever, but who are suffering from what is termed subclinical rheumatic fever. The possible existence of subclinical rheumatic fever may be suspected in every individual in the presence of rheumatic heart disease.

The sedimentation rate determination is a test of nonspecific character and its aid is of minor significance in differentiating patients with rheumatic encephalopathy from other mental patients, because increased sedimentation rates have been observed in the various diagnostic groups(13, 14), under which a patient with rheumatic encephalopathy may masquerade.

The psychotic manifestations of a patient with rheumatic brain disease may resemble any psychosis. If the involvement of the brain occurs in a younger individual, a mental picture suggesting dementia præcox may result(4). If subclinical rheumatic fever involves the brain in more advanced life, psychiatric syndromes such as involutional or senile psychoses may be imitated. Severe depressions have been observed as the result of rheumatic brain disease. Behavior disorders in children following rheumatic chorea are not an uncommon sequel and point to the persistence of the rheumatic infection.

Summary and Conclusions

1. In mental patients with rheumatic brain disease the sedimentation rate was slightly or moderately increased in 85.7 percent. The white blood count was over 10,000 cells in 30 percent of such cases, emphasizing that the sedimentation rate is a more sensitive index of activity of the infection in subclinical rheumatic fever than the leukocyte count.

2. In 4 patients with rheumatic encephalopathy, who had increased sedimentation rates, a correlative histologic study disclosed rheumatic activity on the heart valves and in the vascular system of the brain, kidneys, spleen, etc.

3. Greater familiarity with the existence of subclinical rheumatic fever in apparently physically healthy mental patients, in the presence of rheumatic heart disease, will bring nearer the time, when this group of patients, in whom rheumatic fever has affected both the heart and the brain, will be accurately recognized.

4. The sedimentation rate is of little value in contributing to the differentiation of patients with rheumatic encephalopathy from other mental cases.

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THE THERAPEUTIC USE OF PROLONGED SODIUM AMYTAL NARCOSIS [1]

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The first use of prolonged sleep induced by soporific concoctions lies somewhere in antiquity. In more modern times, the use of ether by Long (1842) and Morton (1846) gave narcosis-producing drugs a utility hitherto unrecognized. Under the impetus of the speculative interest thus aroused, this type of drug found early application in the treatment of the psychoses. Griesinger(1) in 1861 remarked:

> High expectations were formed of ether and chloroform when anesthesia was first discovered; and certainly complete and rapid recovery has occurred in several cases of recent active melancholia. But numerous observations have shown that frequently (although not invariably) a temporary remission of the melancholia and mania, sometimes a complete lucid interval, follows the awakening from the narcotic effects of chloroform; soon afterward, however, the morbid symptoms returned, and with each inhalation the remissions gradually shorten until they can no longer be obtained.

By 1900 more than 40 sleep-producing drugs had been used to produce prolonged narcosis. Neil Macleod(2) at that time used sodium bromide in his "bromide sleep" which he characterized as "A New Departure in the Treatment of Acute Mania." It is judged that Macleod in meeting the necessity of caring for his patients in their homes in Shanghai, China, really induced a therapeutic bromide intoxication somewhat akin to the drug intoxication here under review. He does not speak of his patients experiencing a delirium. Some of their recorded reactions, however, are very suggestive of such behavior. Ragg(3) is disinclined to credit Macleod with the innovation of: "A New Departure in the Treatment of Acute Mania," and refers to Clouston as having used "bromide" in a similar manner. On personal review of the administrations of bromide by Clouston we do not believe them comparable to the method outlined by Macleod. Clouston's experience is summed up in the following statement: "I have used the bromides alone in acute mania extensively and experimentally. In small doses it seems to have no effect. In very large and continuous doses, say a drachm every three hours continued for many days, it will cause bromism, and quiet the patient, but when its influence is over he becomes as bad as ever. I have never seen any medicine where the maniacal excitement and the physiological brain-torpor of the drug seemed so visibly to fight for the mastery." A little later came trional(4), veronal(4), somnifen (5), chloral(6), dial(7), pantopon, adalin, sodium luminal, avertin, and many others. Loevenhart(8), Lorenz(9), and Bleckwenn (10) made noteworthy contributions. In 1925 Wright(11) apparently without knowledge of the work of Macleod, but stimulated by the suggestions of Ulrich(12), reported his "Results Obtained by the Intensive Use of Bromides in Functional Psychoses." His ". . . . plan of bromide intoxication," although less heroic than that of Macleod yielded encouraging results. Lindemann (13) in 1931, in evaluating the studies of Lorenz and Bleckwenn found that small doses of sodium amytal given intravenously produced ". . . . a mild euphoria and a release in inhibitions and reserves in both psychotic patients and normal individuals." In 1932 Palmer and Paine(14) reported their use of sodium amytal in prolonged narcosis in the psychoses. In 1937 Palmer and Braceland reported: "Six Years Experience with Narcosis Therapy in Psychiatry." Sodium amytal was the drug again favored by them. Narcoanalysis was brought into use by Horsley(16) in 1936, by which term he sought to imply a combination of narcosis and psychotherapy. In 1941, Gottlieb and Hope(17) used sodium amytal intravenously to evaluate prognosis in schizophrenia. In the settings of war, Grinker and Spiegel(18) in 1944 introduced the term, narcosynthesis; which procedure is now frequently supplemented by hypnotism(19).

[1] Read at the 102nd annual meeting of The American Psychiatric Association, Chicago, Ill., May 27-30, 1946.

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The purpose of this study, which has been carried on since February of 1938, has been the finding of an efficient less time consuming method of therapy for the borderline personality disorders. Knowing that in the excitement stage of etherization, of alcoholic intoxication, and in the verbalizations of the various deliria, there is a dramatic loosening of inhibitions and often an unveiling of painful repressions, it was judged profitable therapeutically to formulate a method by which such exposition might be made to the advantage of the patient. However helpful the partial and full narcosis phases of the therapy are, it is specifically the production of a constructively expressive delirium which is the main object of the procedure. Awareness that the creation of an artificial state of delirium is not without some risk is freely admitted. Nevertheless, emboldened by the literally shocking, and to some extent destructive techniques of insulin comas, metrazol convulsions, electroshock, and prefrontal leucotomy to obtain constructive end-results, the deliberate use of a delirifacient drug was undertaken. Of the several drugs available sodium amytal was chosen.

The Patient

In this study, only patients falling in the general classification of borderline conditions have been selected. The following conditions have been considered appropriate for selection: Various neurotic manifestations, exaggerations, fixations, and eccentricities; psychoneuroses; neuroses of war; reactive mental depressions; certain involutional and senility reactions; incipient manic-depressive reactions; and early schizophrenic behavior. These groupings include most of the selections made, yet not all in these groups are chosen, nor are they judged to be eligible. Occasionally the method has been applied to psychotic patients, but in such cases it is usually supplemented or followed by electroshock or insulin therapy.

The selected patients may be of either sex and of any age. The youngest patient treated was 14 years, the eldest 74. Contraindications are serious cardiac disease, pulmonary disease, impaired renal or liver function, and blood dyscrasias.

Prior to therapy, the patient must consent and next of kin must give written permission for the procedure. Before treatment also, the somatic status of the patient is thoroughly evaluated—blood Wassermann, complete blood count, urinalysis, nonprotein nitrogen, blood sugar, and stool analysis are routine. Basal metabolism determination, glucose tolerance and phosphorus determinations, electrocardiography, and electroencephalography are done only on indication for differentiation or reassurance purposes. Just prior to treatment, the eliminative functions of the patient, state of hydration, and temperature are thoroughly checked.

The Method

A patient carefully selected, both somatically and psychically, is the subject. Sodium amytal is available in $3\frac{3}{4}$ grain, $7\frac{1}{2}$ grain, and $15\frac{1}{2}$ grain ampoules. A $2\frac{1}{2}\%$ solution in distilled water is administered intravenously at the rate of 1 to 2 cc. per minute. The initial dose is either a $3\frac{3}{4}$ grain or a $7\frac{1}{2}$ grain dose, and is usually administered on the evening before the full course of treatment is to be instituted. Only next of kin are permitted to visit the patient, and these visitors may see the patient only when he is thoroughly narcotized, or during a 12 to 24 hour interval immediately following cessation of drug administration. The drug is usually given intravenously, but may be supplemented by 3, 6, or 9 grain doses by mouth in the course of the treatment, especially if intravenous medication should be difficult. Occasionally the drug is administered intramuscularly and rectally. The patient is usually kept asleep from 12 to 20 hours out of the 24. During the time that he is awake, frequently he is somnolent and lethargic, but the aim is to have him periodically sufficiently awake to take liquid nourishment and to attend to eliminative functions. The usual period of narcosis is from 5 to 12 days, occasionally a few days longer.

Ingestion of solid foods is judged unwise during the period of narcosis. Fluid intake is highly important and throughout the days of narcosis is always kept between 3,000 and 3,500 cc. in 24 hours.

The goal of therapy is a toxic drug delirium in which the patient will not only talk freely, but also will act out and actually abreact some of the painful repressions which have been previously inaccessible. Immediately it is found advisable to discontinue the drug, fluids may be reduced to 2,000 cc. or 1,500 cc. per day in order to stimulate the onset of delirium. Occasionally such delirium is initiated by a convulsion. None of our patients has experienced more than 4 such convulsions during treatment. General tremulousness, photophobia, a staggering gait, and thick hesitating speech are frequently present. After the delirium is in full swing, fluids are usually increased to the original 3,000 to 3,500 cc. per day.

Toxicity is not always easy to recognize. Prior to the toxic stage, the patient has been carried along on doses of sodium amytal, varying generally from 7½ to 15½ as a rule, but occasionally as high as 20 or 22 grains per dose. The effects of the first doses of amytal are very carefully evaluated, especially regarding the blood pressure. It is usually during these earlier doses of sodium amytal that a serious fall in blood pressure occurs. After several doses the blood pressure seems to stabilize as the patient becomes somewhat tolerant of the drug. Any one intravenous dose after the patient has had his first dose of adjustment is usually carried to the point where the corneal reflexes disappear, and occasionally from ½ to 1 grain is added beyond that point. On the earlier administrations of the drug, the patient will sleep as a rule from 4 to 10 hours, occasionally longer. Later, the number of hours of narcosis obtained after an individual dose gradually becomes less. This fact has been looked upon as a reasonably reliable indication of growing toxicity. The patient who first sleeps some 4 to 10 hours on an individual 15½ grain dose will sleep no longer than 3 to 4 hours, and if the patient has been under more or less continuous narcosis from 4 to 8 days, then very careful attention is paid to spacing three 15½ grain doses so that they can be studied very carefully as to the actual length of time the patient sleeps after each dose. If the period of sleep after each of three such successive doses is consistently less than 3 hours, it can be reasonably concluded that the patient has reached a stage of toxicity which will result in a therapeutic delirium within 2 or 3 days after the abrupt cessation of further administration of the drug.

The supervising psychiatrist should have frequent contact with the patient, and should constantly be on the lookout for signs of toxicity. Impairment of motor function seen in faulty co-ordination, staggering and insecurity of position generally, thick halting speech, occasional photophobia, and complaint of blurring of vision are usually suggestive of some degree of toxicity. The psychic manifestations of toxicity defy adequate description. Often the stream of talk and the content of thought, as directly observed by the psychiatrist, or as recorded in the nurses' notes, are very helpful, and the presence of a tendency to relevancy in the patient's remarks for several moments to be followed by irrelevancy are psychic indications suggestive of toxic modification.

Should the patient become incontinent of urine, or experience retention necessitating catheterization, toxicity must be considered. Occasionally, however, a patient will experience these impairments during the second or third day of the narcosis, and even in the absence of otherwise excessive reaction to the drug. All in all, with very watchful observation, toxicity and the appropriate time for the discontinuance of the drug can be determined in trustworthy manner. If, as previously stated, it is judged that the optimum time was not reached, then a reduction of fluids frequently still will bring about the therapeutic delirium desired.

With our changing professional personnel, we nevertheless obtained about 50% therapeutic deliria in our patients. Were it possible in a general hospital to have the same professional team carry through the full therapy in each case, it is believed that a percentage of 75 could be reached. If in the sodium amytal narcosis therapy, a therapeutic delirium is not obtained, there is, nevertheless much benefit derived by the patient. This is seen in his spontaneous readjustments to hospital environment and also in the discussion of his problem. He is much more accessible to analytic questions, and repressed material is more readily obtained.

The complete dissolution of the patient's conscious resistance during the narcotic hours seems to be highly beneficial. Nearly always he welcomes further inquiry and discussion, and his attitudes are more readily re-shaped. Psychiatric determinants previously unobtainable frequently come to the fore, especially if the psychiatrist will appropriately utilize the patient's utterances to well placed questions during his semi-conscious periods.

Reference also should be made to the fact that during the earlier doses of sodium amytal the administration may be so planned that analytic interrogation can be carried out as successfully as under sodium pentothal. The narcosis stage, however, is different from this earlier amytalization.

The Delirium

If correct estimations have been made and if administrations of the drug are abruptly stopped some time between the sixth and the twelfth day, the therapeutic delirium is usually experienced from 48 hours to 3 days after cessation of the drug. Occasionally delirium will set in 4, 5, or 6 days after the drug has been stopped, and rarely as long as 7 or 8 days. The delirium lasts as a rule from 3 to 6 days, occasionally only 2 days; again, it may last as long as 10 days, rarely longer than 2 weeks. It is judged that when the reactions ascribed to the delirium extend beyond 2 weeks, it is more a matter of slow remobilization of the patient's personality reactions than a protracted drug toxicity. Opportunity for psychotherapy, analytic and synthetic, has its place during the delirium and reassembling of personal behavior and attitudes, as well as during the period of amytalization and the period after the patient has fully recovered from the administrations outlined. It is judged that the psychiatric results obtained are always constructive and helpful, although not always as spectacularly evident in some cases as in others. There is amnesia for experiences while narcotized, but only partially, and sometimes not at all, for behavior in delirium.

The data obtainable during the therapeutic delirium vary with each patient, being often very colorful, and many times bringing out material of which the patient was previously quite unaware. Much of the conduct of the patient in the delirium is a frank acting out, or abreaction, of repressed desires and earlier experiences. This can be made clear best by a brief case review.

P. A.—This maiden lady of 46 first made contact with the hospital 10 years ago. At that time her principal complaint was gastro-intestinal, and review by the gastro-enterologist disclosed malnutrition, hypothyroidism, secondary anemia, chronic irritable colon, and a very definite "functional nervous disturbance." The physical findings were essentially negative except for the signs and symptoms common to the conditions named. The patient did not return to the hospital for further attention until April 1944, complaining then of pruritus perinei and eczematous lesions in the axillae. Following review by several physicians and clinics, the referring physician in Minneapolis diagnosed neurodermatitis complicated by a deeply ingrained psychoneurosis.

The parents had separated during the early childhood of the patient. This necessitated care in an orphanage for a year or two. She was then reared by her maternal grandparents with whom she lived to the age of 27. Both her childhood and her early womanhood were decidedly unhappy. Her mother was always hostile toward her, and needed her only when in trouble. The mother remarried, but this did not improve matters. The patient was much closer to her father who never remarried. Frequently she took trips with him. She felt highly secure in her relationships with him. She had one married sister and her parents were both living at the time her therapy was undertaken. She came under our care in May, 1944, and after preliminary studies, sodium amytal narcosis therapy was selected as the treatment of choice. It was carried through between July 2 and 10 of that year.

She was admitted to the hospital on May 29, 1944, and during the 34 days preceding narcosis, a well qualified psychiatrist questioned her on 7 different occasions during the intravenous administration of 7½ grains of sodium amytal. Although a few significant orienting phrases were obtained, no important repressions were elicited.

During the 7 days of prolonged narcosis, the attending nurses recorded many of the spontaneous remarks of the patient during her semi-conscious periods. On the fifth day: "I don't like women, they're so catty—the men, I like them, (pause) I like to talk to them." Later,—is crying because she feels she should have been promoted to the head of her department . . . . she does a lot of talking and worrying about her family. During the morning of the sixth day: "Have our boys reached Paris yet? . . . ." Crying because people used to tell her that her buck teeth made her so she wasn't pretty . . . . wants to know if her daddy went home. At 5:00 p. m. on rousing: "This is a different room. . . . . Is there a new baby out there?—My mother didn't want me. . . . . Why can't daddy come to see me—He never bothers me—Mother does sometimes, but daddy doesn't—I can't blame mother for her condition—that's how she became when she

lost her baby. . . . . I didn't marry 'cause nobody wanted me." About four o'clock in the morning of the seventh day of her narcosis, she remarked: "I thought I could see such horrible things before my eyes—then I see beautiful things—colors—I don't know whether I should enjoy them. You told me that's imagination. O, what a horrible long night I'm having. I don't think this is worth it." The drug was discontinued at 12:30 p.m. on this day—7/10/44.

During the interval from the discontinuance of the drug to the beginning of the toxic delirium (12:30 p.m. 7/10 to 3:00 p.m. 7/13), the patient's conduct was not especially unusual. Some of her reactions and remarks, however, are worthy of record. At 9:00 p.m. July 11 after a visit from her physician, she righted the pictures on the walls of her room. She had turned them face to the wall on June 27 while "peeved" at one of her attending nurses. During the afternoon of July 12 she shampooed her hair—"because it smells." Nurses recorded: The patient is in very good spirits. At 7 o'clock that evening the patient remarked: "I feel so good today," and an hour later it is again recorded: "I feel so good It has been so long since I felt good." At 10 o'clock the nurse notes that the patient did not remember having been visited by her attending physician that day, although he did see her at 10:30 that morning. In her note of 3:00 a.m. 7/13, the nurse writes: She thinks that the glands in her body are now increasing in size, and that they are now 10 years younger—which means she still could have a big family. During this interval (7/10 to 7/13), the nurses repeatedly record that the patient is tremulous, "shaky," and complains frequently of hyperacousis,—"all noises seem magnified and amplified."

Shortly after visited by her attending physician at 2.30 p.m. (7/13), at which time the patient seemed to be moderately well in contact with her environment, she hastily came out of her room, went to the nurse, and decided she had better give away her jewelry, and wanted: "A priest to come at once and give me the last rites. I won't be here long. When it gets dark that is the time. The doctor gave it away that I'm going out. See my eyes and my arms, I'm so dehydrated." Slept 3 hours 7.00 to 10.00 p.m., but later that night was very busy, was talkative and restless. The next morning at 11 o'clock she was dressed, including coat and hat, and was attending "Billy's birthday" (a nephew). At 12.30 p.m. she was very much occupied with "two tons of moth balls." The nurse persuaded her to rest on her bed. At 2.30, however, when seen by her physician, the scene had changed again. As he came to the open door of her room, he found her standing by the window looking anxiously over the hospital grounds to a busy thoroughfare. She stood immaculate and still, hair in faultless coiffure, equally faultless cosmetic touches to face and hands, dressed in a gown of cerulean blue with dainty slippers of the same color. The physician approached and addressed her in a low voice: (Waiting?) Radiantly she quickly turned, and announced: "Yes, today is my wedding day. See?" Then she proceeded to show her physician about the room calling attention to certain feminine touches she had made. (And who is the lucky man?) "George—he should be here now." After reviewing her expectations and learning the identity of George, the physician withdrew. On inquiry as to status of the patient that night, the nurse reported: She's lying quietly in bed now, says she is dying.

At 7 o'clock the next morning (7/15) the nurse recorded: Voided in bed. At 10.00 a.m.: The patient remarked: "They should get $3,000 from their grandmother." At 1.30 p.m.: The patient tore up her bedclothes to make a proper costume because she is an opera singer and must dress accordingly. At 2.45 p.m.: Is talking in a natural tone of voice about wearing navy blue to a press conference. Later, she is selling babies to imaginary people in the balcony. At 3.00 p.m.: Talked about Americans eating babies for dinner.

When seen at 7.00 p.m. by her physician, she was lying quietly in bed, and on seeing him, moved cautiously and maternally. Remarked with a gentle touch about herself here and there: "These babies." (Babies?) "Yes, I have dozens of them." Then, with devotion in her eyes, she gave endearing pats to this one and to that one. In this obvious ecstasy of contentment, the physician took his leave. At one o'clock in the morning of the following day (7/16), the attending nurse records: Patient in bath room washing her breasts, and saying: "My, these babies are messy." At 8.30 that morning, the nurse writes: Says, "I've been dead for 10 days. God is love, but, if I am dead, why don't I die? I cannot die. There is so much work to do, babies to take care of—lovely babies . . . ." At 10 o'clock of the next day (7/17), the patient was found crying. Remarked: "All my nighties are dirty . . . . and no one comes to see me and to take them home." Except for reference to the continued maternal reactions of the patient, the nurse makes no further significant record until 12.30 p.m. of July 18: Involuntary stool and urine in bed (probably in parturient effort or in final disgust). Eight o'clock of the morning of July 19 found the patient very cooperative and helpful to her attending nurses. At 3.00 p.m., the attending physician left an order that the patient might walk about at will on the open air porch of her hospital floor. At 7 o'clock the next morning (7/20), the patient announced: "I've slept so well." Two hours later found her reading the newspaper and 2 hours later still she was sewing and knitting. At 5.00 p.m. the nurse recorded: A good day. Seems in very good spirits. Eight o'clock the following morning (7/21) found her planning her convalescent vacation with a sister and nephews. At 11 o'clock during the forenoon nurse writes: Patient is very happy to have heard from George, and that he has been promoted in his firm. At 9.00 p.m. the nurse notes: The patient says: "I've just begun to realize that there's nothing to live for—no one to care about me." Says that she has been through the stage of imagining that people like and care for her. The next 2 days were not unusual. The patient continued to plan for her convalescent vacation. July 24 found her behavior well within average limitations, appeared thoroughly ef-

fective in her personality expressions, and during the afternoon expressed happiness over a long distance call from George. It was judged that patient had reintegrated her personality reactions effectively and well.

Convalescently, the patient spend a helpful vacation with her sister and nephews in St. Paul. She returned to her former position in October of 1944. She made 3 out-patient visits in 1944 and 3 in 1945. On each occasion, it is recorded that the

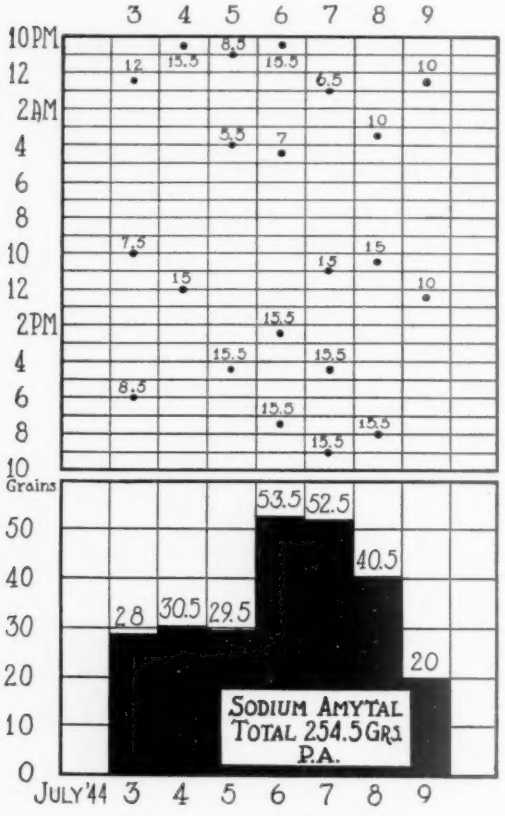

CHART 1.—Treatment chart.

Patient had received a number of intravenous doses of sodium amytal during the days preceding her intensive therapy, hence the usual test dose on the evening before initiating the treatment was considered unnecessary.

patient was holding her gains and carrying on adequately.

On a recent visit at our request, it was judged that her present personality behavior is thoroughly within the average. She admits of no complaints except an occasional headache, and on direct questioning will admit occasional irritation of perineum. "But, really Doctor, I think I'm doing quite well, and I hope you think so when you remember that my father died last December and my only sister died two weeks before that—I did have to take two weeks off at the time of my father's death." The patient is still a maiden lady, and we strongly suspect that George continues to hold a place in her matrimonial aspirations, despite a proposal long overdue.

Application of the medicinal fraction of the therapy and the somatic reactions of the patient may be read, in part at least, from the following charts:

First, in the treatment chart, may be noted the administrations of the drug throughout July 3 to 9, inclusive. All the doses were given intravenously and the time of day is plotted. In the lower part of the chart the total in grains for 24 hours is recorded in graph form.

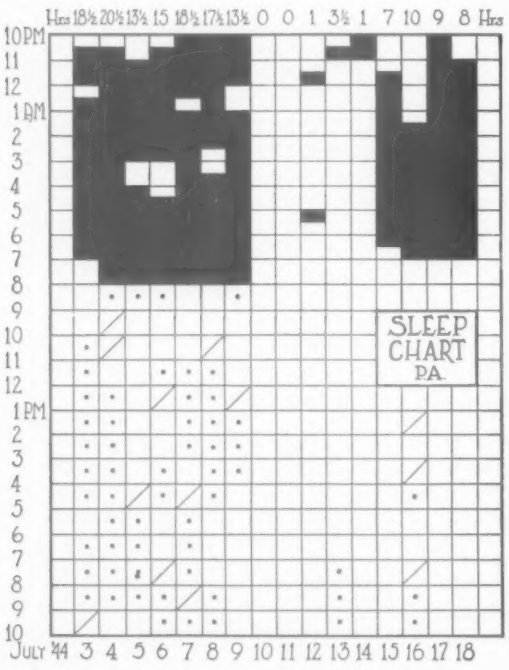

CHART 2.—Sleep chart.

The 24 hours represented on sleep chart are arranged as follows: The first hour of sleep begins at 10.00 p. m. Accordingly, "night" for the patient extends from 10.00 p. m. of one day to 8.00 a. m. of the following day. "Day" from 8.00 a. m. to 10.00 p. m.

Secondly, observe in the sleep chart that each hour of the 24 is accounted for, and that the "night" hours are plotted in solid black, one square to the hour. Sleep during the "day" hours is charted a dot to a square for one full hour and diagonal line across the square for a half hour. Note also that the patient did not sleep at all on July 10 and 11 and only one hour, 3½ hours, and one hour on July 12, 13, and 14.

Thirdly, the composite chart shows temperature and pulse; weight, 106 pounds on July 2 and 104 on July 18; and food intake as judged on portion of trays cleared. One square represents one quarter of food served per day. For 4 days, July 5 to 8, inclusive, only fluids were allowed, and are recorded in cubic centimeters.

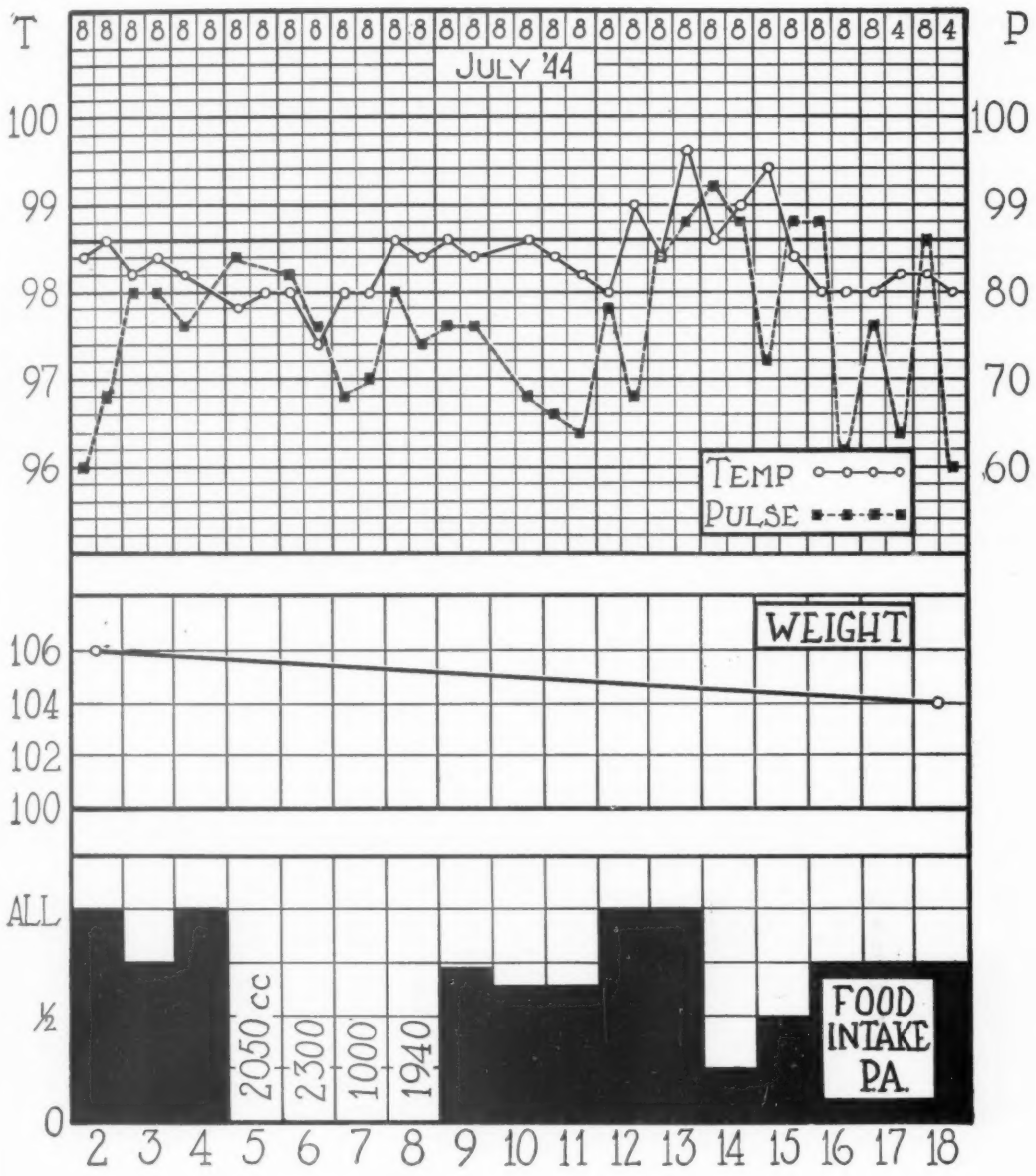

CHART 3.—Composite chart.

THE FAILURES

Failure to obtain the desired therapeutic delirium and most of the undesirable reactions on the part of the patient which now and then are encountered are judged to be due more to mismanagement of the treatment setting of the patient and the faulty applications of the method than to imperfections of the technique itself. Patients not experiencing a therapeutic delirium are schooled to be satisfied with the results obtained for the time being. Occasionally there is opportunity for a second period of narcosis therapy at a later carefully selected time. Rarely has recourse been taken to a third course of treatment.

Some of the difficulties encountered in this method include: Too rapid administration of the sodium amytal with a precipitate drop in blood pressure, occasionally an arrest of respiration to the point where artificial respiration is necessary. Stimulants of choice

have been adrenalin, sodium caffein benzoate, and coramine. Impaired respiration due to mandibular relaxation and "swallowing of tongue" has occurred only rarely. Aspiration bronchitis, pneumonitis, or pneumonia following nausea and vomiting during treatment has occurred a number of times without fatal results, but with the deduction that administration of the drug had been untimely or some other omission had been made inadvertently.

Results

As stated before, it is judged that all patients to whom the sodium amytal narcosis has been administered have profited therapeutically, some more than others. On reviewing our more than 200 cases, it may be reliably stated that about 80% of the patients have benefited by the therapy to a point where they personally recognized their improvement, not only 2 weeks after the conclusion of the treatment, but also as long as 18 months to 7 years later. Of the other 20% it may be said that the treatment was incomplete, should have been repeated, or a poor selection of patient had been made. It is not claimed that the therapeutic delirium induced by prolonged sodium amytal narcosis or the narcosis is in itself curative, any more than insulin hypoglycemia and the shock therapies are of themselves curative. They are, however, highly ancillary to the psychotherapy and the directive management of the patient.

Discussion

The precise reason why sodium amytal produces the narcosis that it does in the manner that it does and the way in which the delirium follows are still controversial matters. The various theories of sleep and its induction by drugs come in for consideration. Some probably would adhere to the semicoagulation theory of Claude Bernard. Others might prefer the ingenious hypothesis of Bancroft and his co-workers. Whether we include or exclude the thalamus and the hypothalamus from our conjectures is also debatable. Personally, I prefer to adhere to a simple interpretation such as arrest of cellular metabolism in some manner and degree. I prefer even to omit, and in this regard prefer only to mention that tissue oxidation or lack of it may be a factor in such cellular metabolism.

The therapeutic effect of the narcosis or the recovery of the patient from it seems, in the first place, to make the patient wholly dependent upon his physicians and associated personnel. This total resignation on the part of the patient to forces outside of his own control should probably receive more credit than is usually given to it.

The fact that in his narcosis the patient sleeps at a much deeper level than he does naturally probably arrests much of the subconscious activity, and possibly some of the unconscious psyche, thereby bringing into a state of rest various processes of personality integration. When the narcosis has lifted with an intermediate delirium, the various former personality formulations must be remobilized and rearranged. We judge that it can be reliably stated that such reassembling and rectification are always in the direction of normalcy. Naturally, the best reintegration is obtained under guidance of the interested physician and psychiatrist.

Summary

During the past 8 years we have used prolonged sodium amytal narcosis in the treatment of border-line neuropsychiatric disorders. The therapeutic technique is usually so planned as to produce a toxic delirium after the cessation of drug administration. This therapeutic delirium is judged to be reliably restorative and reconstructive. Various degrees of narcoanalysis and narcosynthesis are permitted, but most benefit follows delirious abreaction. All patients to whom the treatment was administered were helped, some more than others. Dissolution of the faulty personality behavior and constructive recasting of the psychiatric problem probably occur through improved physiological rest and a remobilization of thought processes during an irresponsible and impersonal state of psychomotor activity which is temporarily out of volitional control, and is thereafter always reintegrated at a more acceptable level.

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PSYCHOTHERAPY IN CHILD SCHIZOPHRENIA [1]

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INTRODUCTION

Child schizophrenia is now recognized as a psychopathological syndrome, and a number of confirmed cases have been reported in the literature. Several approaches have been used in the treatment of a fairly large number of cases, considering the relative infrequency of the disease: insulin shock, electric shock, metrazol, benzedrine, deep or light sedation, and psychotherapy, including psychoanalysis.[2] As a rule the therapeutic procedures are carried out in a hospital or specialized institution. Ambulatory treatment does not seem to have been tried with schizophrenic children as it has with adults. This presentation deals with the psychotherapy of 7 ambulatory cases, 6 boys and 1 girl, over periods ranging from a few months to 2½ years, with varying degrees of success. Furthermore, since not enough time has elapsed for follow-up evaluation, it is concerned only with methods and immediate results.

I. SUMMARY OF CLINICAL DATA

Owing to time limitations, pertinent data on the 7 cases are briefly summarized:

At the time of admission, the ages ranged from 3 years 10 months to 7 years 9 months. In 3 cases (Thomas H., Peter K., Seymour W.), the onset was acute in a background of earlier adjustment that could not be described as normal although it was at first so reported by the parents. The onset was insidious, and the child was brought to treatment after several years of frankly pathological behavior in the 4 other children (Bernard D., Brian M., John N., Judith Z.). In the latter group, no precipitating factors were noted, and therapeutic help was sought mainly because of pressure on the part of the school, or as a prerequisite for admission. Poor adjustment, bizarre or disturbing behavior had prompted the request for treatment.

Information on the family background, though often incomplete and not fully reliable, pointed to a relatively high frequency of neurotic and psychotic illness in the antecedents, with schizoid characteristics fairly common among the parents. Although several of them were highly successful in their chosen work, none of the parents could be considered happy and well adjusted, either individually or in their marriage relations.

Careful physical and neurological examinations ruled out organic pathology in all cases. The 7 children presented frankly psychotic symptoms, and none could be considered as only schizoid personalities. At the time of examination, contact and affect disturbances were noted in all, with marked to total withdrawal of interest, and flattening or dissociation of affect as significant manifestations. There was bizarre and distorted thinking in all, and hallucinations were present in 4 children, with indirect and questionable evidence of perceptual defect in the other 3. Stereotypy, mannerisms and motor dissociations were observed in all 7 children, as were peculiarities in pitch, rhythm and modulation of speech. All children showed peculiar reactions to sound, sometimes a complete unawareness; or, on the contrary, they exhibited startle reactions to minimal stimulation. They showed a more than usual interest in and knowledge of music, and 2 were considered exceptionally gifted. While it was generally not possible to ascertain the intellectual level through psychometric testing, owing to contact disturbance, the early developmental history and observed behavior ruled out congenital mental deficiency.

BRIEF OUTLINE OF PROTOCOLS OF THE SEVEN CHILDREN TREATED

1. *Bernard D.:* Insidious development over a period of years. An only child. Treated from 5 years 5 months to 6 years 6 months. Withdrawn after 66 therapeutic interviews. Out of contact; generally mute, not responsive, except for some

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[2] See bibliography.

irrelevant mutterings; very rarely there were spontaneous, short, relevant sentences. He seemed to be unaware of people as people (climbed over them as if they were furniture). Bizarre behavior, including eating garbage, smelling strangers, etc. Auditory and visual hallucinations, some of which were associated with attacks of acute anxiety. Preoccupied. Stared into space. Heavily tainted hereditary background on both sides of the family, from the point of view of neurotic and psychotic illness. A successful business man, the father had nevertheless suffered delusions of persecution and severe anxiety symptoms since adolescence. The mother had an emotionally deprived childhood, was compulsive, and had a strong drive for perfection, particularly expressed in her handling of the child. Birth was dry; high forceps were used. Psychomotor development was normal, but very early speech development presented abnormalities (could say difficult words, but did not use language for purposes of communication). The child had an extraordinary knowledge of recorded music. No psychometric test could be done, owing to poor contact, but the child seemed alert. He was brought up very rigidly and was kept away from children for fear of dirt and disease. Masturbation was severely suppressed. A traumatic episode involving sexual stimulation by his nurse took place when he was about 2 years old.

There was enough improvement in affective contact for the child to enter school and make a relatively good social adjustment there. The mother, pathologically identified with this child ("We enjoyed our measles; I got undressed and got right into bed with him."), developed considerable resentment over his relation with the therapist ("He plays with you as he doesn't seem to want to play with me.") and decided to withdraw him, claiming that the school was sufficient for continued improvement. At the last check-up, when the boy was 8½ years old, he had made little progress, and was travelling about with his mother.

2. *Thomas H.:* Acute onset in a background of poor adjustment. Older of two children. Treated from 6 years 5 months to 6 years 10 months. Twenty-three therapeutic interviews at the time of writing. Referred by the school physician, because of shyness, seclusiveness, peculiar behavior, lack of contact with other children. He had become totally mute at 2½ years, following a traumatic episode, and never recovered normal speech function. There were intermittent mutterings, usually not related to current situations. Shortly before admission he was found laughing, after having thrown out of the window a pet dog of which his younger sister was very fond. In the family background there was no evidence of mental disease; 3 of the grandparents (2 had died) suffered hypertension and heart disease. Both parents were fairly well adjusted, except for the mother's moodiness, tenseness, and tendency to worry. The father, an airline flier, was infrequently at home; and he did overseas duty for several months during the child's fifth year. Birth took place at nearly 10 months, by Caesarian section. Psychomotor development was normal, with precocious speech development and extensive use of rhymes. Speech for communication was scant. Infantile habits, such as thumb sucking and masturbation, were dealt with severely. His social development seemed normal, except for a tendency toward shyness, until he was 2½ years old. At that time he suffered a severe burn while watching his mother prepare the 6-months-old baby's bottle. This was a very traumatic experience (as ascertained later, related to death wish toward baby sister); furthermore, it kept him away from children for several months. He became afraid of adults (especially doctors), would not mingle with other children, and became mute. As shown by observation and his teacher's report, he was of at least average intelligence. From the age of 2½ years to 6 years 5 months, he had little or no contact with other children; when exposed to them, he was impulsively aggressive and destructive. When he was first observed, at 6 years 5 months, there was no affective rapport, he shrank from physical contacts and approaches and was mute, except for explosive short sentences not relevant to current situations and which he uttered in a peculiar low-pitched voice. He was also prone to sing quite accurately a large variety of tunes. There was marked motor restlessness as he wandered about the room, at times whispering, with peculiar facial grimaces and mannerisms, such as putting his fingers on his closed eyes. At times, he seemed to hallucinate. He was not at first interested in toys but with a good deal of pressure began to use them: At the beginning of every session, he would put all the toys on the floor in a somewhat concentric arrangement, with the outer line always made up of all available planes, without paying attention to the observer, and shutting his eyes tightly when she addressed him. This was a symbolic activity of great significance which offered the initial opportunity for developing contact through interpretation of the seemingly nonfunctional play. (Recall that his father was a flier.)

Following the development of transference to the therapist, there was some improvement in this child's social contact, as reported by the mother and his teacher. He even began to talk in class, briefly, at intervals. He is still under treatment.

3. *Peter K.:* Acute onset in a background of earlier poor adjustment. An only child. Treated from 3 years 10 months to 5 years 1 month. About 60 therapeutic interviews. He was referred because of excited behavior and acute anxiety of approximately three weeks' duration. Prior to the acute onset, there had been a week of mild excitement related to some home difficulties. The acute episode took place in the course of a visit to the Museum of Natural History with his father, when he suddenly became upset while looking at totem poles. The following night he was sleepless and seemed in a daze. He spent the next two weeks alternating between a "stupor-like daze" and periods of excitement, during which he would scream or make such statements as "I can't be myself, I'm scared I'm not myself," or ask his parents to remove the rhinoceros and Indians with sticks, etc., from his room. He seemed to hear but did not answer. There was

considerable drooling, and blocking in his speech. He was given sedatives without results. Information relative to the antecedents was scant and considered inadequate. The maternal grandfather had a violent temper. The maternal grandmother, who lived with the family, wept easily, was compulsive and worrisome. She had taken an active part in the care of this child. The father had a good deal of drive. The mother was moody. She had a depressed episode shortly before her marriage, after hearing of the suicide of a strange woman in her house. She was emotionally dependent on her mother and markedly ambivalent toward her. The child was born after 13 years of marriage. Pregnancy lasted 8 months and was associated with maternal depression. Following the discovery of a congenital dislocation of the hip, the baby was in a cast from the age of 4 to 10 months. His complete immobilization made care difficult, and the maternal grandmother was brought in at that time. The mother felt guilty about this, and felt that her mother had taken her place in the child's affections. Labor was short, with middle forceps. The baby was "knocked out by mother's paraldehyde." Psychomotor development was precocious, and the child was of very superior intelligence. Many fears and nightmares, especially in the period following a herniotomy at 2 years 4 months, were reported. Masturbation was frequently noted, usually associated with a dazed expression. He had always been destructive and difficult to manage—related to a large extent to the obvious conflict between the mother and the maternal grandmother. Also, he had severe temper tantrums at various times. He showed a marked interest in music and was able to recognize themes and titles in a large collection of classical records. When first seen, he presented all the earmarks of acute schizophrenic illness: he was out of contact, his behavior was autistic, and at first unintelligible; he had auditory and visual hallucinations, generally associated with acute anxiety; alternating with periods of mutism, there was pressure of speech with a peculiar pitch and modulation. Neologisms were numerous. Motor restlessness was marked, alternating with catatonic posturing and drooling.

Throughout the first 9 months of therapeutic contact the mother was present at the interviews, owing to the child's extremely disturbed behavior and the mother's own severe anxiety at the prospect of separation. The child improved to such an extent that he was able to attend school part of the last nine months, and he made a relatively good adjustment there. Following a 3 months' absence in the summer, treatment was resumed along customary lines and the child was seen without his mother. There was complete recovery from the acute episode, with a sequela of neurotic anxiety for which he is currently being treated. Adjustment at school is now good.

4. *Brian M.:* Insidious development over a period of years. Second of 3 children, 2 boys living. Treated from 7 years 2 months to 7 years 8 months. Withdrawn after 10 therapeutic interviews, allegedly because of difficulties in transportation. However, the psychiatrist to whom he was transferred thought that the female psychiatrist was "a threat to the mother," who had emphasized to him the good rapport of the child with his first therapist. The patient was referred by the school for bizarre behavior, facial grimaces, irrelevant speech and activities. Information about the hereditary background was considered inadequate. The father, a brilliant writer and public speaker, had an obsessive drive for power and achievement. The mother was so much on the defensive that it was difficult to get a true picture of her personality, but one was impressed with her emotional blunting and inability to give warmth and affection. She seemed to have had great difficulty in recovering from the loss of her first child shortly after birth. There are indications that the mother was apprehensive about the birth of the patient; however, labor was easy. The child had pyloric spasms, was always a feeding problem, and developed eczema at 6 months. Very early he showed an exaggerated reaction to noises, especially the human voice. He was always physically timid. At 2 years his speech and language development presented peculiarities; a psychologist who was consulted at the time stated that the child preferred to express himself in song. At the present time he is considered a musical genius. He began to develop facial tics at about 18 months. At 3 years he had a very large vocabulary and showed pressure of speech. Cyclic vomiting was present intermittently between the ages of 2 and 6 years. When he was 3½ years old, a brother was born; he was considerably disturbed by the absence of his mother and spoke about her as if she were dead. Through the years he had a fear of death with varying degrees of intensity. Between the ages of 1 and 2½ years, he was kept from contact with children by his father's old nurse who took care of him. His social adjustment was always poor. He never made friends, did not seem to notice other children, was withdrawn most of the time. Already considered abnormal by several psychologists and one psychiatrist, at the age of 2, he was not brought to treatment until the school (at 7 years) made treatment a prerequisite to continued attendance. When first observed, this child was apprehensive, restless, spoke in a peculiarly modulated voice, at intervals was preoccupied and out of contact. There was considerable pressure of speech. Numerous neologisms, incoherence and irrelevancy were marked. He was at least of high normal intelligence, as evidenced by occasionally relevant utterances and an unusually extensive vocabulary. (Psychometric testing was not attempted, owing to paucity of contact.) Obsessive thinking and activities about feces and flatus, and a touching compulsion were observed.

While there was little or no change in his behavior, contact with the therapist was attained. The complex symbolism of his thoughts, phantasies and drawings was becoming intelligible.

5. *John N.:* [3] Insidious development over a period of years. Oldest of 3 children, 2 boys living (second child still-born). Treated from 7 years 9 months

[3] This case is to be published in full.

to 10 years 5 months. Over 200 therapeutic interviews. His social adjustment was poor, and he had been rejected by several schools. He was on the verge of being dropped by a private school because of bizarre behavior and inability to establish contact with children and teachers. The hereditary background was heavily tainted with neurotic and psychotic illnesses in the direct and collateral lines. Both parents were brilliant, with schizoid characteristics. Marital adjustment was poor. In utero the patient was not as active as his siblings. Labor was prolonged. He was not interested in sucking, and was always a feeding problem. Psychomotor development was normal, except for relatively late speech development. At an early age he was, and has continued to be, interested in the phonetics rather than the content of speech. There was still occasional enuresis at the time of admission, and he also deliberately voided in the midst of family gatherings, or in public places. He had numerous fears at various times. His behavior was already considered abnormal at 4½ years, when he was first seen at a mental hygiene clinic. In various nursery schools and kindergarten, attended since the age of 3 years 5 months, he did not seem to know how to play, was fascinated by toilets, masturbated frequently, and was a constant problem socially because of lack of contact, but was "intellectually far beyond all expectations." For instance, he learned to read by himself. Very early he showed an interest in music, and at the age of 4 years he was able spontaneously to improvise and reproduce complex melodies, although it was not possible to teach him music owing to lack of rapport, and his musical productions were conspicuously disorganized. He was considered a musical genius by professional musicians. When first seen, he presented a picture of acute anxiety with anxious facial expression, moist skin, marked motor restlessness, excited jumping associated with extraordinarily dissociated and nonfunctional motor patterns of the head, arms and trunk. As a reaction to auditory hallucinations, he put his hands over his ears or put his fingers in the canals, made grimaces and muttered. There was marked autistic behavior involving thinking, speech, and motor patterns. He was heard muttering to himself and laughing irrelevantly, with no awareness of the observer's presence. There was no spontaneous contact. He was prone to smell and lick any part of the observer's clothing or body when he happened to be near her. There were obsessive thoughts about bathrooms and toilets, and neologisms were numerous. Verbal productions generally were irrelevant and uttered in a peculiar voice with odd patterns of phonetic rhythms. When he made use of toys, it was in a nonfunctional way.

This boy showed a definite improvement, although he continued at times to be preoccupied. Whenever he became upset or frustrated, he was prone to have a brief recurrence of some mannerism. He also tended to be compulsive and had constricted interests and activities. The motor restlessness lessened considerably, and he was able to attend school for over two years, where records indicated slow, gradual improvement in his social adaptation and contact, as well as in scholastic achievement. However, it was in his musical interests and activities that his progress and integration were best reflected. He became related to his music and for the first time was able to take musical training. It is felt that his musical abilities can now be utilized for future professional attainments, and individual integration.

6. *Seymour W.:* Acute onset in a background of maladjustment. Oldest of 3 children. Treated from 7 years 7 months to 8 years 5 months. Approximately 60 therapeutic interviews. Prior to the initiating of individual treatment, he had been for one year on the ward of a psychiatric hospital, where the diagnosis of schizophrenia was made. When observed, he was out of contact. There were irrelevant speech and laughter, obsessive concern with toilets, a large variety of mannerisms, and he did not respond to the therapist's approaches. Frequently he muttered to himself in a peculiarly pitched and modulated voice, and used neologisms freely. Information about the hereditary background was considered inadequate. Both parents had limited intelligence and constricted interests. They emphasized that there had never been difficulties in the home until the onset of the child's illness. The mother, who had had an unhappy childhood, showed considerable drive toward perfection in the bringing up of her children. Birth was uneventful, after three weeks' delay; psychomotor development was normal. There was a good deal of thumb sucking, which the parents attacked with a variety of methods but without results. There was a relapse in bladder control at 2½ years, coincident with the sister's birth, and enuresis was among the presenting complaints. There was intense jealousy and difficult behavior at the time of his sibling's birth, and three or four months before this event he had become unusually quiet. This was probably coincident with being told about the expected baby. He showed many fears in the course of his development, and social adjustment was always poor. At 4½ years, a psychiatrist suggested play therapy—a suggestion which was not followed, and the mother felt guilty over this. Refused admission by several nursery schools, at 6½ years he finally attended a Hebrew school. There he had acute anxiety attacks related to his fear of using strange toilets. This fear was intensified by the threat of a teacher that he would nail him down on the seat or flush him down the toilet if he did not attend to his needs like other children. He had a marked interest in and knowledge of music and some of his delusions involved identification of human beings with radios.

The child developed a good rapport with the therapist, and increasingly longer periods of relevant thinking and speech expression were noted. He had been in a private school for a short while when the school was closed, so that social contacts were limited almost exclusively to his family. Although he was still difficult to manage, because of autistic and aggressive behavior, there was improvement in this area. He was later admitted to a

special day school where, after a difficult period of adjustment, he showed improvement in contact and ability to learn. He is still under treatment.

7. *Judith Z.:* Insidious development with an acute exacerbation. Older of 2 children. Treated from 5 years 6 months to 6 years 4 months. Withdrawn after 44 therapeutic interviews, allegedly for financial reasons. After a period of observation at a children's hospital, she was referred for treatment, with the following presenting problem as formulated by the examining neurologist: "She is mute most of the time, sometimes she answers questions distinctly. Echolalia—usually when asked questions she starts the question in an almost inaudible whisper, almost synchronously with the examiner. There is scarcely an interval between the words of the examiner and the patient. Irrelevancy of speech—patient's mother has reported statements having no bearing on the subject of conversation. Auditory hallucinations—patient's mother reported that while at her bedside she stared up at the wall and repeated the question 'what'; patient's father reported that while at home prior to admission she once cried out, 'Get those people out of my room.' Negativism and resistiveness—at times when being examined, especially with tongue depressor, she screams impulsively. Bizarre acts, such as sitting in crib with blanket over head. There is incontinence of urine at times. She requires spoon-feeding usually." Information relative to antecedents was considered inadequate. The father, an only child, had been spoiled, was immature and domineering. The mother was an apprehensive, insecure young woman who was inhibited by fear of her husband and his family. There had been considerable conflict between the paternal and maternal families, owing to clash of personalities and divergence of religions and traditions. Labor was long. Breech presentation was followed by version. The baby had a cyst on the anterior fontanel, of which there was residual evidence. The child needed stimulation at birth. She gained rapidly; her psychomotor development was precocious, especially with regard to speech. Bowel control was achieved at 7 months. However, bladder training was difficult and at the time of admission she was still wetting the bed frequently. Masturbation must have been repressed early and effectively, judging by the mother's indignant tone in her denial of this habit. Since approximately 5 months of age, there had been noted frequent rocking associated with "staring into space." The birth of a sibling at 2 years 9 months was reported as having been uneventful. At that time, however, there was a series of illnesses, principally affecting the upper respiratory tract. She also began to act phantasies—such as, she was married and had two children—so realistically that the parents experienced a good deal of concern. She did not play with other children. It was not clear whether she could not or did not for lack of opportunity. When she was 4 years old she was "living in a world of her own"; and in a group of children she would stand aside and watch them rather than play with them. She was always a feeding problem; she was so active as to make handling difficult; she had numerous fears, generally at bedtime. At 5 years, 6 months before her admission to the hospital, she had a severe case of measles, following which she became still more seclusive. She developed auditory and visual hallucinations and asked to have "eyes" removed from the walls of her room. She became mute; "she began to do things that were definitely odd." When first observed, at 5 years 6 months, she was out of contact most of the time, appeared to be listening to voices. Echolalia, echopraxia were noted. Pitch was peculiar. There was perseveration of motor activity and speech and marked motor restlessness. There was a tendency toward catatonic posturing, and no relevant response to the therapist's approaches. There was marked dissociation of affect, and neologisms were frequent. She had a very large vocabulary and an extensive repertoire of popular and classical musical works which she sang and acted dramatically.

Some improvement was noted, in that the motor restlessness had decreased considerably, and contact with the therapist showed progress. The mother also reported that the child's rapport with her parents and sibling was increased.

II. Considerations of Therapeutic Methods

It has long been thought that schizophrenic patients could not develop a transference relation with their therapist. However, the reports of Zilboorg(14) and Frieda Fromm-Reichmann(6), among others, indicate that such a relation can be established. The patients treated by these authors were hospitalized adults, but the rationale of treatment of ambulatory schizophrenic children is the same—whether psychoanalysis or other type of psychotherapy is selected as the method of approach.

If the outstanding feature of childhood schizophrenia is the loss (or lack) of affective rapport—and the majority of authors are agreed on this point—the rationale and prerequisite of therapy must be first to establish contact. To this end, a variety of means can be used, so long as they allow the therapist to break into the child's autistic world: silent participation, acceptance of all mannerisms including those related to excretory functions, imitation of the patient's words and gestures, in fact any attitude which, without threatening the child's precarious security of his locked isolation, may impart to him the feeling that his behavior is understood and accepted. Immediate interpreta-

tion is usually not available, since the very nature of schizophrenic illness makes the child's behavior unintelligible. Nevertheless, it is the apparently meaningless maze of rituals, mannerisms and neologisms exhibited by these children which makes it possible eventually to penetrate their autistic world. A careful history often provides clues for the interpretation of bizarre attitudes, especially when considered in the light of minute details of moods, motor patterns, facial expressions, speech utterances or silences observed in the therapeutic interviews. For instance, when 4-year-old Peter K. shrieks, in an acute panic, "Don't put pennies in me," his thinking and feeling experience is at first utterly incomprehensible. A typically schizophrenic process, this psychopathological deviation (delusion) is in essence the end result of a condensation phenomenon. All the elements necessary for an analysis and understanding of his apparently irrelevant and autistic behavior do not present themselves in proper sequence and relation, but they appear either in the anamnestic material or the observed behavior; they may also emerge as a result of various hypotheses brought to the attention of the parents, and confirmed in part by them after specific inquiry into obscure areas of the early development. As obtained through these various channels, it is eventually learned that: 1. The child has hallucinated "a little old lady" who wanted to do him harm. . . . . 2. The little old lady was traced to a traumatic episode in his recent past (he was frightened the previous summer by a strange woman who had a dilapidated appearance), but also identified with his grandmother who had taken care of him since infancy. . . . . 3. When she came to live with his family, the grandmother brought a dog which terrified the patient, and with which he identified at intervals, when he went about biting people. . . . . 4. The grandmother read to him, over-dramatically, with the child in a sort of trance, the story of "The Three Little Pigs," and at times the patient identified with a little pig eaten by a wolf. . . . . 5. Finally, the child owned a "piggy bank" in which the family and visitors were accustomed to put pennies, and the sight of this toy had recently thrown him into such a panic that his parents finally removed it to some inaccessible place. It is obvious that the child was going through a terrifying experience, and it was only the unravelling with and for him of the complex condensation patterns that relieved the anxiety bound up with them. Over and over, the material was held and abreacted, every fragment singly and in combination with others, and the piggy bank itself was brought to the play room in one phase of the therapeutic development.

The analysis of another autistic manifestation, in 8-year-old Seymour W., is also briefly reported for purposes of illustration: For several weeks the patient made "irrelevant" gestures toward the gluteal region of people, familiar and unfamiliar, who came within his reach. This caused his parents to be disturbed, punitive and inhibitory, which increased rather than stopped the activity. When he made this gesture toward the physician and she asked why he was doing it, the child in a panic cried, "I won't do it again, I'll be a good boy!" a stock phrase, expressive of his guilt feelings, and which he used profusely with his parents. She reassured him that she did not mind his activity, that he could go on with it all he wanted to, but she would like to know the reason for it. As might have been expected, this brought no immediate response, but on careful observation it appeared that the gesture was a "winding" gesture. Several other observations had previously been made, which seemed to have a bearing on the autistic behavior: 1. He was obsessively concerned with good and bad radios, green and brown radios. . . . . 2. He expressed obsessive interest in, also anxiety about, the bowel function. . . . . 3. He mentioned several times that a hypothetical boy, "he" (himself, obviously), was singing, reciting and keeping everybody up. . . . . 4. At intervals he sang melodies which seemed exact reduplications of parts of radio programs. . . . . 5. He made drawings of radios, in which facial features and winding knobs were prominent, and to which he occasionally added feces. . . . . 6. Recurrently, he expressed anxiety about his "meckey" (in turn, penis and feces) being washed down the toilet by a rabbi, which, incidentally, kept him at intervals from moving his bowel several days in

succession. . . . . 7. He objected to the physician's singing a certain Christmas carol, although he occasionally sang it himself. It was not until the latter fact was utilized in the therapeutic approach that an understanding of the autistic activity was gained. Once, as he began the "winding" gesture in the accustomed pattern, the physician deliberately started to sing the Christmas carol. The child, in a panic, cried, "Doctor D. is not a radio—I don't want her to be a radio." Thus, it was obvious that what he had been doing right along was winding people as radios, or testing them as people-radios. Besides the reassurance that the physician was not a radio but a person who was very fond of him, the interpretation was over and over given to him of the several fragments bound in his autistic gesture. While the castration anxiety, the confusion over animate-inanimate objects, male and female sex, anal and genital birth, and other pathological expressions obviously formed the background of this autistic gesture, the understanding of this gesture made possible the breaking down of condensation patterns which had served to isolate the patient from the outside reality world, and also rendered his behavior unintelligible.

Repetition is an essential requirement of therapy, with these very disturbed children, as it is an essential requirement of learning and maturation in the very young normal child, but to an even greater extent. The young patient may appear to have grasped an interpretation given him, and react as if emotionally able to absorb it, later to revert to some form of regression seemingly in contradiction with the progress recently achieved. Indeed, one is sometimes in doubt about the latter, until further observation indicates that some gain has been retained in spite of the apparent loss.

Regression in schizophrenic illness is not a regression *in toto,* and this is perhaps more clearly shown in the child than in the adult. There are specific areas of excessive affect binding, with the regressive patterns appearing unevenly. Neologisms and other autistic forms of expression would thus represent the end results of phenomena of condensation, transfer, substitution, fixation and dissociation of affect; they seem to have become separated from the whole psyche and assumed a meaning of their own, in appearance nonfunctional and noncommunicable.

Breaking into the autistic world of the schizophrenic child often provides the first "sharing" (a beginning in human relationships) he has experienced since his illness was well established. While on the surface appearing oblivious to the outside world and relatively settled or fixed at a compromise level, he is actually in a state of constant conflict, and his anxiety is overwhelming. This "sharing" is the first step toward bridging over to the outside world, and for a long time it is the only contact, however slight and fleeting, he is capable of developing. An illustration is seen in the case of Peter K.: About $2\frac{1}{2}$ months after the initiating of treatment, his mother reported that on the previous day at home he had attempted to reach with a broomstick the ceiling light, in which he had previously hallucinated rhinoceros and totem pole faces. At this point, however, he seemed to be testing reality. His mother, fearing that he might injure himself, suddenly snatched the stick; in so doing, she broke the bulb and injured her hand. The mother had been very upset and handled the situation inadequately. Anxiety and guilt feelings obviously had been aroused in the child. Indeed, on that day he showed more withdrawal and preoccupation than on previous interviews, and the therapist deliberately brought up the traumatic episode for abreaction. The child immediately said, "You should have hurry up," indicating that in this time of special stress he had conjured up the therapist's help.

An *active* approach on the part of the therapist is particularly necessary in the initial phase of treatment; generally speaking, it is also indicated, at all stages, to a greater extent than in the treatment of neuroses or behavior disorders. Transference is usually established after considerably longer periods of treatment than is the case with any other mental illness, and it also requires more affection, patience and alertness on the part of the therapist than in other mental illness. When it develops, transference seems more intensive (probably because emotional relations with the outside world are so restricted) than is the case with neurotic chil-

dren. Peter K., who was throughout articulate, even when unintelligible, protested as the therapist was preparing him for the summer's absence, "Don't you ever say goodbye to me!" Seymour W., as he emerged from a world in which emotional relations with persons have no place, asked with a bewildered expression, "Am I your little boy?" Once established, transference plays its usual rôle as a therapeutic instrument, but at the same time it may be an additional obstacle to therapeutic progress, in that it represents a threat to frustrated and very disturbed parents. For this reason, close contact must be kept with the parents in order to interpret the child's behavior and, in particular, to anticipate and render more acceptable the increase in regressive, hostile or antisocial patterns which may appear coincidentally with improved contact. Release of maternal guilt is throughout an important item in the therapeutic procedure. An interesting aspect of ambulatory treatment has been that asocial and antisocial patterns shown in public places, to and from the office, have been less than was anticipated, even when regression and autistic expressions were coincidentally very marked in the therapeutic situation.

In the course of treatment, phases of earlier emotional development are relived; although not in their original form, and in spite of pathological distortion, they are still readily recognized. For instance, the "I-not I" phase of individuation anteceding the ideo-affective organization of language in the normal 2-year-old is clearly identified in Seymour W's anxious struggle which followed a long period of bizarre thinking, neologisms and inarticulate language, as he said, "I am me. . . . . If I am me, I am not you."

Results have been encouraging and, while the prognosis remains guarded, it seems that ambulatory treatment of schizophrenic children, whenever feasible, presents advantages over treatment in institutions, as separation from the home achieves further severance from whatever minimal contact may have existed prior to the initiation of treatment.

Summary

Seven schizophrenic children, 6 boys and 1 girl, received ambulatory treatment, psychotherapy, over periods ranging from a few months to 2½ years, with varying degrees of success. Summaries of the 7 cases are presented, with emphasis on therapy and progress. On the whole, chances for relative recovery and adjustment seem to be greater than is the case with therapy in institutions.

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PREJUDICE AS A SOCIOPSYCHIATRIC RESPONSIBILITY [1]

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Only very recently have psychiatrists come out of their offices and expressed their feelings and understanding of interpersonal relations as they pertain to the complicated emotional pressures and reactions in the community and the world. Franz Alexander at the 1943 meeting of the American Orthopsychiatric Association in a symposium on world government pointed out among other things that the political insecurities and reaction to fundamental needs on the part of small and weaker nations was analogous to the reactions of children in various types of family groups. Kenneth Appel has written extensively on the psychopathological reactions of nations. Karpman and others have contributed to our understanding of the emotional factors in prejudice and Dr. Alport of Harvard has devoted almost all of his recent writings to the subject of bigotry and prejudice; the most recent being his editing of the March 1946 *Annals of the American Academy of Political and Social Science*—a volume limited to the discussion of prejudice. Freud's "Psychopathology of Everyday Life" of course introduced much of our fundamental understanding of interpersonal relationships.

However there continues to be more research in and more presentation of papers on the alleviating of symptoms of schizophrenia than on the understanding of some of the emotional pressures and community frustrations that may have a good deal to do with the etiology of that dreaded and malignant disease. None of us is surprised. It is much more simple and almost entirely without personal emotional threat to study complete physiological changes and reactions or record the various modifications of behavior as the result of myriad shock procedures. But the study and understanding of a community emotional illness in which we, too, may be involved, is so threatening that to hide our collective heads in psychologically rationalized sand has become the accepted and conventional procedure.

It is not my place to discuss the political or the economic factors in the etiology and maintenance of prejudice. The emotional factors as psychological reactions, not moral, have an equally important role in this etiology. Many attempts by non-psychiatrically oriented individuals to discuss the emotions of prejudice have always deteriorated to discussions of moral issues involved and have, of course, collapsed under their own breast-beating. The psychological factors in prejudiced reactions take on definite patterns that are as coldly scientific as the number of red blood cells in a centimeter of blood. The investigation also must be done in a scientific and unemotional way so as to stay clear of contamination by politics, economics or personal feelings.

Much of the relative neglect of investigation into the causes of prejudicial feelings can be directly placed on the investigator whose personal fears will not allow participation or even interest in a subject that may very well demand, as he proceeds, a sort of self-analysis or a very unsatisfactory anxiety producing series of rationalizations.

I shall not attempt in this very brief paper to give results of an exhaustive investigation, but instead I shall try to outline a point of view and suggest methodology and responsibility of the psychiatrist in this important phase of the welfare of mankind.

Certain important factors stand out. First of all, the fallacy that we are all created equal, which can be interpreted as actually a fear of being different. The feeling that those who appear, act and speak differently must be inferior is based primarily on the fear we have of these people because we do not know or understand them. The feeling or expression of their inferiority is an aggressive and hostile one and as such is motivated by the insecurity aroused by not knowing.

[1] Read at the 102nd annual meeting of The American Psychiatric Association, Chicago, Ill., May 27-30, 1946.

A new member of any group regardless of his race, color or religion is immediately under suspicion and looked upon with some misgivings. He is never completely accepted until he is known. This is not an unusual procedure, and in normal emotional growth the child is frequently faced with new and unknown persons or things from which he either withdraws or whom he attacks. When understanding replaces newness, fear and its reactions are replaced by participation. Difference no longer is a barrier, but a constructive stimulus for healthy emotional growth.

Unfortunately, all the forces in the family, or in a larger sense the community, are not so set up that the child or citizen can gain positive strength in his drive to understand and solve the new, strange and different things in his environment. The parents or parent persons such as teachers, policemen, politicians, the church, etc., have not resolved their own conflicting feelings about new and different things. They, too, are insecure and dependent and searching for supportive strengths. And they, in a larger sense, are denying the existence of difference by trampling upon it or avoiding looking at it. Because of this immaturity on the part of the parent person, the difference becomes a negative factor in emotional growth. Fear of this difference increases and aggressive reactivity to this fear becomes an accepted and acceptable behavior pattern.

Let me give as an example the reaction to racial differences of an emotionally healthy child of 4—of fairly well integrated parents. This child has seen people of many different races in her home. They have all been people. She was never forewarned not to mention their differences in their presence. There was no variation in her shy reactions when introduced to people the first time. The shyness did not wear off faster or slower or change in intensity in relation to the color or physical characteristics of the new people. Soon they were all her friends. A crisis occurred one evening when a particularly dark-skinned Negro was in her home. She said to her father, "My, he's black, isn't he?" The father agreed, but no attempt was made to warn her about mentioning this outstanding difference any more than she would have been warned about mentioning someone's blond hair or bald head. It was not bad to be black, it was not a sign of distrust, it was nothing to be concealed, and so it was immediately accepted as a positive difference and not mentioned again during the evening. As a matter of fact, the child and this man became good friends.

A less integrated father—a man who retained certain fears of difference and had little understanding of other racial groups might have laughed, made disparaging remarks, or even warned the child about such men and the gulf of non-understanding would have widened and fear replaced emotional growth.

This brings me to the second large factor in the psychology of prejudice. There are some who cannot, regardless of opportunities and education, allow themselves to know and understand others. These are the fringe who have not quite been completely accepted by groups themselves. They may have some personality difficulty that does not allow positive personal relationships; they may not be completely acceptable because of the artificial standards of the group itself—such as exclusive clubs; or they may have or be concealing racial or religious backgrounds that would identify them with a minority. For example, the Jew is anti-Negro and the Negro anti-Semitic. The Reformed Jew of German or Spanish background who feels he is just beginning to be accepted is anti-orthodox and anti-Russian Jew. There are always the "shanty" and "lace-curtain" Irish and more recently in large cities have appeared West Indians in contrast to Negroes.

The second group composed of those who are never certain of their position and acceptability, are the most difficult to do anything about and by their activity, crystallize nebulous and unconscious fears in the majority. Because they feel more threatened by minorities, they are more active and verbal in their aggressive feelings and the more secure majority then finds an outlet when it is threatened and can focus all of its own doubts and unresolved conflicts on the unknown minority. They are the Gentiles who look Jewish and, unable to accept this, become violently anti-Semitic to prove to the world their non-Jewishness and then develop and organize large groups to give them

strength in this endeavor. They are also the neurotic individuals who afraid of their own sexuality spread rumors of the sexual atrocities of Negroes. The Negro, by virtue of not really being known, is a common enough sexual symbol to those to whom sex, too, is not understood and therefore something to be feared.

All of these individuals, who because of their immaturity cannot accept differences, must set up artificial programs of sameness and exclude all others. This protects their status quo and makes the much more difficult job of emotional maturation unnecessary for existence. Because of this attempt to stimulate an intrauterine existence which is truly non-differentiated, the resistance to any introduction of differences is tremendous and results in segregation and in some instances overt aggression.

One more aspect of this problem must be considered. The reaction of the group discriminated against. All of us struggle in our growth process toward overcoming our feeling of difference and finally being accepted by some group. Non-acceptance, of course, increases one's insecurity and feelings of difference. Sometimes the reaction takes several positive forms—the difference is intensified by those excluded forming their own groups—an aggressive form of segregation; or by virtue of outstanding individual performances, individuals can gain special recognition. The latter can be carried as far as the "honorary Aryan" status given certain Jews in Germany because their skills were needed by the *Wehrmacht*.

On the other hand if the minority individual or group cannot react positively, aggressive and destructive reactivity becomes the method of intensification of difference. The gangster activity of certain middle European American immigrants, behavior problems in discriminated against school children, or the more acceptable political activity of the Irish and the numerous Jewish, Negro, Italian and Irish boxers are several examples.

The every day living of the average Negro is filled with so many tensions and frustrations that it is amazing that any can live in our culture and not develop serious emotional maladjustments. When the white person of any religious group wonders where he will have lunch, the Negro must determine where he *may* have lunch—the quality and price of the food being secondary. Finally when he is in a restaurant, he wonders whether he is being served quickly because the service is good or because they want to get rid of him. Conversely when he waits without service, he wonders if all the waiters are busy or he is being slowly but surely discouraged. These tensions gradually, by means of many defense reactions, become less conscious, but the anxiety in some form or another remains. Isn't the etiology of this widespread endemic neurosis a psychiatric problem and responsibility? The psychiatrist must begin to take the blinders off and look for and eradicate etiologic agents that cannot be worked through on the chair or couch.

The war and postwar shift in population has forced recognition of these tensions where fluid segregation no longer allows our conniving at the problem. As an example, Vancouver, Washington, a city of 50,000, had three Negroes before the war and now has 8,000. It is up to us to help the old established majority populations to know and understand these new and for the most part frightened people. They must be helped in understanding that the apparent aggression of the Negro is a reaction to fear of again being segregated, deprived of equal opportunities and physically threatened. They must be helped too, in understanding their own attempt at segregating is based on fear and that the bogey of real estate deterioration is based on this malignant segregation process in a vicious circle.

Fleetingly we have touched upon the ever present emotional action and reaction of our heterogeneous culture in which acceptance and recognition of differences is one of the major steps toward the accomplishment of individual and communal emotional maturity. It is obvious that although political and economic factors have been avoided in this very brief discussion of prejudicial reactions, that economic and political uncertainty is an outstanding factor in the production of individual and group insecurity. This constant bogey of insecurity is then of necessity translated and projected onto everyone and everything that by its very difference is immediately a threat. The emotionally secure child who

can receive ego support from a strong parent learns to accept and understand differences. The insecure child intensifies his feelings of difference and insecurity by projecting his fears onto the changes in his total environment. In our form of dependent culture, political certainty and economic security become the strengths necessary in our continual drive toward emotional maturity.

The crisis of war and its resultant economic and political upheavals have increased the dependency needs of groups and individuals. One cannot accept differences when one is searching for one's own security. In this search differences are intensified by the tighter organization of groups so as to better resist the threats of other groups. This suspiciousness and distrust extends beyond racial and religious differences—labor and capital, liberal and conservative, American, Russian, English instead of accepting differences and establishing a working, practical, mutually participating and inter-dependent society, see their differences as insurmountable threats, become more aggressive in their reactions to each other and search for some security within themselves. Skudder McKeel has statistically demonstrated that those who are anti-Jewish and anti-Negro are also anti-labor, anti-Russian, anti-English and of necessity, anti-United Nations. The United Nations ideal in itself is a mature, positive acceptance of differences.

It is apparent then that in this world, where insecurity and prejudicial reactions are increasing and the release of atomic energy adds to the general anxiety, the psychiatrist cannot be smug and content. He cannot remain in his office and feel that the very few adults and children he may help toward a more integrated emotional maturity is his full contribution toward a more mature and complete society. He must realize that group therapy and inter-dependent understanding in its largest sense is his responsibility. He must put into practice his own understanding of the emotional factors in education. He must participate with those actively working toward a breaking down of political and cultural isolationism—if only to help these groups understand psychological pressures and reactions.

By this participation, it is hoped that the psychiatrist can really contribute to the gradual elimination of the barriers to our collective emotional maturity so that differences can be utilized and accepted and that discrimination and its aggressive reactions become a rare, delimited and curable disease.

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CONVULSIVE SHOCK THERAPY IN PATIENTS OVER SEVENTY YEARS OF AGE WITH AFFECTIVE DISORDERS [1]

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The value of convulsive shock therapy in affective disorders was first reported by Bennett in 1938(1). Since this time innumerable reports have confirmed the therapeutic value of the treatment. Some reports even claim a certain specificity in the therapy of affective disorders.

Reports of the use of convulsive shock therapy in the aged are few. Robinson (2) in 1941 reported a series of patients, all over 60 years of age, 16 of whom were treated with convulsive shock therapy. Of these 16 patients, 14 made complete recoveries and 2 made social recoveries. In a follow-up study made 6 months after discharge, reports were obtained on 10 of the original 16; 7 had remained well, 2 had relapsed and 1 had died. The oldest patient in the group, aged 84, made a sustained recovery. Bennett(3) in 1941 reported successful results with the combined use of curare and metrazol in aged patients. In 1945 he reported (4) briefly on 25 patients past 70 (the oldest 83). The present report includes these patients in a more comprehensive survey.

Evans(5), reporting on a group of older individuals, listed 5 patients over 70 years of age. These individuals were not segregated in the total report. However, Evans suggests that convulsive shock therapy is not attended by undue risks in the aged.

Mayer-Gross(6) states that electric convulsion treatment can be used without undue risk in the aged. He believes that the treatment is justified by the recoveries or improvement obtained. Of 76 cases in his report, 14 were over 70 years of age.

Although older patients and patients with cardiovascular disease show an amazing capacity to tolerate the treatments well, preliminary curarization affords additional necessary protection. The definite risk of fractures in old, brittle bones is obviated by adequate curarization. This was aptly demonstrated by the case of a patient not included in our group, 68 years of age, who was unduly resistant to curare and obtained no obvious muscular relaxation from the injection. Electroshock was nevertheless administered and the patient sustained a compression fracture in the thoracic spine.

Patients with serious organic complications in addition to cardiovascular disease have also been successfully treated, as reported by Bennett(7) in 1944. Curare modification has, therefore, made possible the treatment of individuals with disabling affective disorders complicated by organic disease or defects connected with age.

TABLE I

DIAGNOSES

	No. of patients
Diagnostic classification:	
Manic-depressive psychosis, manic phase	3
Manic-depressive psychosis, depressed phase	4
Agitated depression (involutional type)	14
Senile depression	6
Reactive depression	3
Total	30

In this study all case histories of patients 70 years of age or older who had been treated by convulsive shock therapy were reviewed and 30 cases of affective disorders were collected.[3] The presenting diagnoses are shown in Table I. Many of these patients were referred by physicians with a diagnosis of organic brain disease or senile dementia. The age range is shown in Table II.

[1] Read at the 102nd annual meeting of The American Psychiatric Association, Chicago, Ill., May 27-30, 1946.

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[2] Resident in Psychiatry from the Clinic of Dr. Samuel Ramirez Moreno, University of Mexico.

[3] These patients were observed in the psychiatric department of the Bishop Clarkson Memorial Hospital, service of Dr. A. E. Bennett.

TABLE II

AGE DISTRIBUTION

Age	No. of patients
70	4
71	7
72	3
73	3
74	2
75	3
76	2
77	2
78	2
80	1
83	1
Total	30

Not one patient in the total group failed to have some complicating organic disease. To be sure, 4 of the 30 patients suffered from arteriosclerosis alone, but 26 had 2 or more organic difficulties. Table III is a survey of these complications.

TABLE III

COMPLICATING ORGANIC DISEASES

Disease	No. of patients
Cardiovascular diseases:	
Arteriosclerosis	19
Hypertension	12
Heart disease	7
Renal arteriosclerosis	1
Peripheral vascular diseases	4
Surgical lesions:	
Hernia	2
Hydrocele	1
Tumors, including carcinoma	3
Respiratory diseases:	
Chronic bronchitis	1
Gastrointestinal diseases:	
Cholecystitis	2
Muscular and skeletal diseases:	
Arthritis	6
Deformities	2
Kyphosis	2
Neurologic diseases	4
Miscellaneous:	
Ophthalmologic diseases	4
Dermatologic diseases	1
Infections	3
Blood dyscrasias	1
Drug addiction	1

The general treatment program began with hospitalization. A complete history and physical and neurological examinations were made on each patient. In some cases, medical consultants were asked to evaluate the organic disease and carry through necessary treatment.

Curare convulsive treatment was begun as soon as possible. Curare dosage in these older patients to produce complete curarization averaged more than 1 mg. per kilo, as compared with younger patients. The number and spacing of treatments were adapted to the individual case; the mininum was 3, the maximum 14. The average number of treatments in any one course was 6.5.

During the course of shock therapy and frequently throughout the whole course of hospitalization nutritional intake was stimulated by means of 20 units of insulin daily before breakfast. In all cases nutrition was rigidly supervised and good weight gains usually occurred. Patients were required to take part in occupational and recreational therapy except when mental confusion was severe.

Within 2 to 3 days after the course of shock therapy was completed psychotherapy and re-education were begun. Although memory defects were frequently still prominent, gross confusion had usually cleared. In senile patients confusion develops readily after a few treatments. The proper spacing of treatments requires close observation to avoid marked confusion. It is felt that the development of insight is important in preventing relapses.

Length of hospitalization varied, being more prolonged in those patients who required preliminary treatment for organic disease before shock therapy. One patient remained 86 days, although he received only 6 curare electroshock treatments. The shortest hospital stay was that of a relatively healthy 74-year-old male who remained 4 days for various examinations and then took treatment as an outpatient. It should be emphasized here that only patients who had previously been hospitalized and who had suffered a relapse or recurrence were treated as outpatients. Of the total group, only 4 patients were thus treated. The average length of hospitalization for the whole group was 39 days.

Duration of psychological disease did not apparently affect the duration of hospitalization. One patient who had been depressed

for 5 years was hospitalized for 42 days, received 4 curare electroshock treatments and made a sustained recovery. The duration of illness ranged from 1 month to 20 years. Of the 30 patients, 13 had been ill for over a year, 17 for less than a year.

Follow-up studies have been evaluated in the charts in Table IV. The elapsed time since completion of treatment ranges from 3 months to 6 years, 3 months.

TABLE IV

FOLOW-UP STUDIES

	No. of patients
a. Immediate response to treatment:	
Improved	28
Not improved	1
Died	1
b. Follow-up study (time lapse: 3 months to 6½ years):	
Sustained recoveries	11
Social recoveries	3
Recurrent attacks	3
Failures	6
Not heard from	6
Deaths * (during treatment)	1
Total	30

* Follow-up data showed that 4 patients later died mentally well, 3 mentally ill.

Of the 28 patients who showed improvement (recovery) at the time of dismissal from the hospital, one-half (14) had relapses or recurrences. Altogether, this group of 14 patients had a grand total of 23 relapses or recurrences. The reason the relapse rate is so high is that 3 patients have had a total of 10 recurrences; probably true recurrences in that each patient has been well a year or more between attacks. Many recurrences can be cleared up with a small number of treatments if the patient is brought back promptly, as illustrated by Case 3. Of those patients who made sustained recoveries, 5 had only one course of treatment and 6 had relapses, were retreated and have remained well.

Six patients relapsed shortly after completion of treatment and since they did not return for further treatment were considered failures. In 3 of these cases insufficient treatment was judged a cause for relapse. In 2 cases further treatment was obtained elsewhere, but relapses occurred within a very short time after treatment and their discouraged families institutionalized both patients. The sixth patient was placed in the failure group since she could not be retreated after a relapse, because of severe cardiac decompensation.

CASE HISTORIES

1. *Sustained Recovery.*—B. O., female, age 73, was admitted with a history of severe depression, insomnia and nihilistic delusions for the preceding 3 months. She was a true pioneer, having lived for many years in a sod house in the Nebraska sand hills. Her prepsychotic personality was of the cyclothymic type and this was her first psychotic episode. In view of the prepsychotic personality type, the lack of rigidity and the absence of senile signs, a diagnosis of manic-depressive psychosis, depressed phase, was made. Physically she was diagnosed as having kyphosis of the thoracic spine, arthritis, hypertrophic type, generalized arteriosclerosis, hypertension and arteriosclerotic heart disease, grade I. She was given 7 curare electroshock treatments. She remained in the hospital 43 days and made a recovery sustained for 3 years. A recent letter from her states, "I am 76 now and to prove to you what I am I'll tell you what I do for pastime. I take care of 300 hens, market their product, buy and haul home all the feed and other necessaries. I drive my little Olds wherever I want to go. I go to K . . . quite often, a distance of 50 miles. . . . " This patient, of course, developed excellent insight.

2. *Social Recovery.*—A. C., female, age 73. This patient was admitted with a history of severe depression at the age of 51. Treated by an internist, she had recovered from the depression after one year but remained obsessional. Three months before admission a severe agitated depression developed. She had always been a very rigid person. In view of the rigid personality and the earlier involutional depression she was diagnosed as involutional depression, recurrent. Physically she was diagnosed as having hypertension. She was given 7 curare electroshock treatments, and thereafter only as she showed depressive symptoms, which recurred until after the thirteenth treatment. Psychotherapy procured a very limited insight. She was dismissed after 57 days of hospitalization, markedly improved. She was followed for several months, during which she gradually became obsessional but not depressed. She was considered a social recovery.

3. *Case of Recurrent Attacks.*—J. W., male, age 71. This patient was admitted with a history of periodic incapacitating depressions for 30 years, none of which had lasted more than a few months. However, this time he had been depressed a year and gradually became increasingly agitated and suicidal. Between depressions he was described as outgoing, with considerable drive, a successful

farmer and business man. He was therefore diagnosed as manic-depressive psychosis, depressed phase. Physical diagnoses were: immature cataract, O. L., generalized arteriosclerosis, hypertrophic arthritis, prostatic hypertrophy and hypertension. Hospitalized for 38 days, he received 7 convulsive shock treatments. He made a good recovery and returned home. Since then he has returned 5 times for treatment. He remains well for about a year, becomes depressed and returns within 2 to 3 weeks after onset of the depression. A survey of his record shows that in the past 5 years and 3 months he has received a total of 38 treatments and has been hospitalized a total of 5 months. Now 76, he has been otherwise well and able to carry on his affairs.

4. *Failure—Insufficient Treatment.*—G. L., male, age 75. This patient was admitted with a history of a mild agitated depression 10 years previous. He was treated by a psychiatrist and recovered in about 4 months. About one month before admission he again developed an agitated depression and became suicidal. He had always been extremely rigid. A diagnosis of agitated depression, involutional type, recurrent, was made. He was severely arteriosclerotic and suffered from peripheral vascular disease with intermittent claudication. He was given 9 curare electroshock treatments during 35 days of hospitalization. The family presented a considerable problem and the patient was dismissed as improved but without insight. He relapsed in less than 3 weeks and was considered a complete failure.

Eight patients have died. The patient who died during treatment was 71 years of age, had mild arteriosclerotic heart disease, but was making an excellent recovery from an agitated depression. She took 6 treatments without difficulty or complications and died during the seventh. Unfortunately an autopsy was not obtained. Four patients later died while mentally well. Two others dying of physical disease while mentally ill are included in the failures. One died at 76 while recovering from her third recurrence in 5 years.

Conclusions

Experience with a group of 30 patients all past 70 shows that convulsive shock therapy is well tolerated by the aged.

Convulsive shock therapy in the aged can be made more safe if curare modification of the convulsion is utilized. The organic defects and diseases of old age are not necessarily contraindications for curare electroshock therapy.

Follow-up studies show that half of this group of patients obtained sustained recoveries or sufficient recovery to remain functional in society.

Evaluation and retreatment of relapses suggest that prompt treatment of recurrences will produce an early remission and prevent prolonged hospitalization.

No conclusions can be drawn regarding the death rate in this group.

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ELECTROSHOCK THERAPY

A Survey of 200 Cases Treated Over a 1 to 5 Year Period in a Private Sanatorium [1]

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This report embodies the results obtained in the treatment of 200 private sanatorium patients followed over a five year period. The treatment given was electroshock, either alone or in combination with sub-coma doses of insulin. In all cases an adequate program of psychotherapy was instituted.

Two primary factors distinguish this group. First, as private patients they voluntarily submitted themselves to confinement and were able to terminate their treatment whenever they or their relatives decided; and secondly, as private patients, few could afford the expense of prolonged care and the loss of time from their occupations or homes.

The average sanatorium stay of the cases reported was 25 days, as compared with 90(1) or more days stay in public institutions for the care of mental diseases. Surprisingly the results obtained with the shorter duration compared more than favorably with the latter. The benefit to the patient and family consisted in the short absence from work or household duties, the retention of all citizenship and competency rights, and avoidance of being labeled as an inmate of an insane asylum.

This does not in any way reflect on the excellent care given to patients in the state institutions, but to the unfortunate antiquated laws that still govern the disposition of those legally designated as insane. Until adequate changes are made in these laws, the above conclusions remain valid and in many cases of prime importance.

The cases reported included 144 women and 56 men, representing all types of mental ills, with the exception of luetic or gross organic cerebral changes. The ages varied from 12 to 83 with a mean age of 42. The average number of electroshock treatments was 8.5 per case, the shortest being 2 and the longest 41.

The acute depressed patient responded most quickly and the recovery rate of 81% was the highest of all groups. (By recovery is meant a complete remission, in which the patient is able to resume his or her normal place in society.) The average number of treatments was 7 per case with a hospitalization period of 21 days.

The acute schizophrenic, either of a paranoid or catatonic variety, responded well, although in this group it was found best to use a combined therapy of electroshock together with sub-coma doses of insulin. The average duration of confinement was 42 days with 68% showing good results. Shock treatments were primarily used to break down resistive or negativistic attitudes and to make the patient more accessible and cooperative.

Insulin treatment started with 20 units, increasing the dosage by 20 units each day until coma resulted. The dose was then reduced and timed so as to avoid deep coma. Treatment was given 6 days a week for 3 to 8 weeks, depending on the response of the patient. All the cases treated were of an acute nature and were seen relatively early in their sickness.

In 29 instances there were recurrences and treatment was again instituted. Most of these responded to a reinforcement course of shorter duration than in the first series. I cannot see that this is necessarily a failure in treatment. As medical men we do not feel that insulin therapy in the diabetic is at fault when a patient who responds well, suddenly relapses into coma and it is necessary to institute heroic life saving measures. Nor do we "throw in the sponge" when it is necessary to redigitalize a heart patient or start a new course of quinine in malaria. The essential, gratifying fact is that we now have an instrument available that in a rela-

[1] Read at the 102nd annual meeting of The American Psychiatric Association, Chicago, Ill., May 27-30, 1946.

tively short period can so alter the outlook of a depressed person that he can once again become a part of his family group. I have given 4 separate courses of electroshock to 5 patients and 3 to 12 patients during a five-year period. None of these patients showed any deterioration or undue suffering from the therapy but on the contrary they were the most grateful of the series. They were able to live 50 weeks of each year with their families, retaining their normal status. Isn't this better than to break up a family group and place the patient in a state hospital? As psychiatrists we are not only treating the patient but the family as well.

Preparation of Patient.—All the patients were given from 1½ to 3 grains of nembutal one hour before treatment. In the acutely agitated cases, from 3 to 15 grains of sodium amytal was given intravenously just before or following the treatment. Intocostrin was used in muscular men and women and in the older patients. A simple headpiece(2) similar in appearance to a radio operator's was used. It was found invariably best to start with a strong convulsive dose rather than with a relatively small dose and then building up to larger doses. I have had no fatalities or serious accidents due to treatment.

Comment

These cases have been under observation now for a period varying from 1 to 5 years. Letters and personal contacts with the former patients were used to determine their present mental status, the reaction to electroshock therapy as to individual benefit, and to ascertain whether or not they would feel free to recommend it to patients suffering from the same malady. The replies were most encouraging.

TABLE I

Electro-Shock Therapy

200 Cases Treated over a 1 to 5 Year Period

Type cases treated	No. treated	Aver. No. hosp. days	No. recoveries	No. failures	% recoveries	No. recurrences
Depressions	161	21	131	30	81	..
Manic-depressives	49	..	44	5	89	..
Agitated depressions	64	..	58	6	84	..
Cerebral arterio. dep.	11	..	6	5	55	..
Reactive depressions	9	..	9	0	100	..
Anxiety neuroses	12	..	8	4	67	..
Involutional melan.	9	..	6	3	67	..
Alcohol., depression	7	..	4	3	60	..
Schizophrenics, acute	39	42	26	13	67	..
Paranoid	24	..	..	..	..	..
Catatonic	15	..	..	..	..	..
Totals	200	25	157	43	78.5	29

Average age of patients treated..... 42
Average No. of treatments..... 8.5
No. of male patients treated..... 56
No. of female patients treated..... 144

Presenting symptoms:
Depressions 74
Agitation 68
Insomnia 64
Recurrences:
First No. 12
Second No..... 12
Third No. 5

There were many factors that were responsible for the evident goodwill and freedom of response to the questionnaire. First was the voluntary nature of the treatment procedure. Most patients were seen in several interviews at the office before confinement. A feeling of confidence and trust in the doctor was established. At the sanatorium informality prevailed and the patient immediately identified himself as a member of a family group. The number of treatment cases was limited to small groups so as to maintain this family relationship. Everything was done to have the patients mix with the others. A community of interest grew with each succeeding day and treatment, especially as each observed the sustained and continuous improvement in

each other. They felt that they were a part not only in their own improvement but in helping with the problems of others. They also saw in the problems of others, factors that were present in their own sickness and they subconsciously gained insight and understanding of the mechanism of their disturbance. They soon saw that they were not alone in their misery and that domestic, economic and involutional situations have much in common between patients. The old association pathways were forgotten with shock therapy and new positive goals asserted themselves. During this period of two weeks, visitation with relatives was discouraged—thus preventing any former associations to be reinforced.

TABLE II

ELECTRO-SHOCK THERAPY

Survey of 200 Patients Treated over a 1 to 5 Year Period

Response by patients to questionnaires.....1946

1. Present mental status?
   - Recovered 161
   - Same or worse..... 39
2. Fear of treatments?
   - No 155
   - Yes 45
3. Recommend treatments for others?
   - Yes 176
   - No 24
4. Number of years since recovery?
   - One year 35
   - Two years 39
   - Three years 33
   - Four years 26
   - Five years 24

No attempt at deep psychotherapy was made during active shock therapy. Reassurance and confidence in their future were the main themes. However, one very important phase was covered thoroughly. In practically every case the families were interviewed and made to see their responsibility in the production of the patient's illness. In many instances severe emotional conflicts were found in the relatives that could also be reached and corrected. Sociological factors whenever possible were changed and bettered.

When the patient was discharged, the family and patient were again seen and the necessity for follow-up therapy at the office was stressed. This was of utmost importance. First, it helped the patient to adjust to the change and stabilized the patient and family, knowing that someone in whom they both placed a great deal of trust was interested in their future; and it reassured the patient on many of the confused mental processes that shock therapy produces, such as memory losses, etc.

Intense psychotherapy was started in suitable cases. In others a follow-up was maintained for continued observation and reassurance and a sincere attempt was made to eradicate the factors instrumental in bringing about their emotional conflicts. A dietician saw all cases where there were any suggestive nutritional disturbances and made the necessary dietary corrections.

I have made no attempt to classify these patients when first seen, beyond noting the acute presenting symptoms. When depression and agitation predominate, I know that good results will be obtained from shock therapy. Psychiatric diagnosis can be attempted later, after proper study of the patients and when they are most accessible to psychotherapy. It is surprising how many mixed cases are seen and how often with an unbiased approach an early impression is altered. It is for this reason that a more flexible approach should prevail in the first few interviews and in treatment.

SUMMARY AND CONCLUSIONS

The total approach to the treatment of the acute psychotic should embody not only the active phase of the treatment, with a complete physical and laboratory study, but a thorough study, of the patient in relationship to his environment. This necessitates an intimate understanding on the part of the physician of the personalities of the entire family group. A human yet scientific approach incorporates the philosophy and friendliness of the old family physician with the dynamic interpretation and understanding of modern psychiatry: a personalized service adaptable to the individual and his family instead of a detached impersonal attitude that is so prevalent in large institutions and that would become more so in so-called Socialized Medicine.

A five-year follow-up program on 200

cases which followed such a program has been studied and presented. The recovery rate under this procedure has been extremely high and has been maintained over a period of 1 to 5 years in 80% of the cases.

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SUB-COMA INSULIN AND PENTOTHAL SODIUM AS AIDS TO PSYCHOTHERAPY[1]

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This paper deals with the results of 6 months' experience in treating chronic anxiety reactions on the wards of a military hospital. The question of adequate treatment of this type of case has always been difficult and the results often disappointing. The problem has recently been emphasized by the number of cases developing during the war. We are recording our results and conclusions because: (1) This chronic group forms an important proportion of the post-war disabilities; (2) It has been neglected from the point of view of treatment; (3) It fairly closely simulates the peacetime variety.

Practically all psychoneurotic reactions have a common basis of anxiety. We are all familiar with the subjective sensations which indicate that emergency physiological body changes are taking place. We recognize these changes as an excellent response for a short term crisis, but we are also aware that when some emotional situation causes persistence of these changes, a true disability may result. The anxiety-producing ideas in the cortex stimulate the sympathetic center in the hypothalamus and thus the peripheral autonomic system, giving rise to tachycardia, gastro-intestinal upset, insomnia, etc.

Psychotherapy, our chief remedy for this condition, may be aided by a symptomatic treatment such as sedation, and here insulin has proved most satisfactory. On the other hand, the cause of the underlying anxiety may be determined by direct questioning or by the use of pentothal. A logical conclusion would seem to be that a combination of the two aids should achieve the best results.

In reviewing recent literature, it appears that the use of pentothal has received adequate attention in America, whereas the use of sub-coma insulin in these conditions, although long used in England, has received little attention on this continent.

[1] Read at the 102nd annual meeting of The American Psychiatric Association, Chicago, Ill., May 27-30, 1946.

Visible anxiety was the primary criterion in the selection of our cases and in the main our ultimate object was to assist these men in achieving a rapid civilian readjustment.

Classification of Types

For purposes of classification the cases were roughly divided into 3 clinical types.

1. *Generalized or "Free Floating" Anxiety.*—In these cases tension, startle reaction, insomnia, etc.—in short the usual anxiety manifestation were the most prominent part of the picture. This group comprised three-quarters of the cases treated.

2. *Psychosomatic Conditions.*—Here the patient had centered his anxiety on an organ, part of the body or fear of a disease—such as syphilophobia. These somatic complaints were frequent, but predominated in only one-fifth of the total group. It is our experience that this type of patient does not respond particularly well to this form of treatment.

3. *Certain Types of Depression Associated with Marked Anxiety Features.*—These were usually battle casualties in which a guilt reaction had developed.

Sources of Material

Patients were of two main groups, viz: (1) overseas men; (2) home service.

In general the former had more acute symptoms, of shorter duration and were basically more stable types of personality. Their reaction to treatment was more prompt and incidence of complete recovery was higher.

Usual Signs and Symptoms on Admission

Complaints were fairly stereotyped and for practical purposes can be grouped without excluding any of importance. The severity and frequency of subjective symptoms and objective findings are shown respectively in Tables 1 and 2.

Adjustment Previous to Service.—This feature is important, in that it gives an indication of the type of psychological material with which we are dealing. Here a comparison between overseas and home service men is interesting and significant. Only 35% of the overseas men have a history of instability in the family background, while it is present in 60% of the home service cases. Childhood neurotic tendencies are present in only 30% of the overseas men, but in 72% of the home service group. About 20% of the overseas men have not previously adjusted well to their occupations, while 32% of the home service men had failed in this respect. The home service men also had multiple factors in family and personal background and gave evidence of increased symptoms under army conditions because of adjustment difficulties.

TABLE 1

Type of symptom	Total	Severe	Moderate
Anxiety	57	43	14
Anorexia	42	16	26
Insomnia	37	13	24
Irritability	25	11	14
Terror dreams	23	11	12
Expressed aggression	16	9	7

TABLE 2

Type of finding	Total	Severe	Moderate
Palmar sweat	47	24	23
Tremors	42	19	23
Flushing	37	16	21
Agitation	22	9	13
Stutter or stammer	10	7	3
Nail biting	7	3	4

Duration of Symptoms

Symptoms were present for periods varying from 6 months to 3 years. The greater chronicity in the home service group has already been noted.

Treatment

Our treatment was entirely voluntary but the short period involved and the enthusiasm of the men already being treated were enough to convince the new men that it was worth a trial. Once on the ward an outline of the treatment was given and the patient was encouraged to discuss his symptoms with the physician. He was given a simple explanation of the origin of the symptoms using Cannon's work on the physiology of fear as a working basis. The formation of the vicious cycle causing persistence of symptoms after removal of the original cause was explained, and the rôle of insulin in breaking this cycle was described.

A complete physical examination followed, and any heart-conscious men were reassured. Two or 3 days later a detailed personal history was taken, and here was the first of 2 places where pentothal was considered. If the man had true amnesia of a painful experience, this treatment was recommended. In any case the possibility and danger of repressing memories were explained, and the impossibility of forgetting was stressed. It was emphasized that he must accept any experience as something which had happened and was now past. He was also warned that when relaxed, perhaps when dropping off to sleep, parts of these experiences might come to mind, and it was explained that once the experience had been recalled in full it was not likely to recur.

Week-ends were used as testing periods. The patient was urged to go home and any difficulties encountered were discussed on his return. The enthusiasm of parents and friends over improvement was an aid to his realization of the progress.

Insulin Treatment

Insulin was used routinely in all cases, the number of treatments varying from 9 to 13. Treatment was started the day after admission and the initial dosage was 20 units, increasing 10 units a day depending on the reaction of the patient. It was not found necessary to go above 70 units in any case to obtain satisfactory improvement. No breakfast was allowed before treatment. Insulin was given at 7.00 a.m. by the nurse and treatment terminated at 10.00 a.m. by glucose drink and food.

During the treatment period the ward was kept as quiet as possible and was darkened sufficiently to promote relaxation but yet not enough to interfere with observation. At all times the patient was kept in bed and under supervision of trained personnel—a trained nurse on the ward and a physician

immediately available. Emergency equipment was always ready but with the dosage used it was needed only 3 times. A short conversation was held with each man at the termination of his treatment. Improvement was mentioned and any new subjective symptoms explained.

Afternoons were kept as interesting as possible with occupational therapy and group activities. This period was also used for psychotherapy.

Treatment was carried out only 5 days a week and Monday's dosage was not increased over that of the previous Friday. It was interesting to note that alcohol and benzedrene, even in small quantities, seemed to increase greatly the reaction to treatment the following day.

Throughout the treatment every effort was made to maintain a cheerful, confident atmosphere. Here the nurse played an important rôle and was therefore carefully chosen. The patients soon entered into the spirit of things and were a great help in building the morale of new arrivals. Twelve patients would appear to be the optimum number for one doctor, but with the turnover every 12 to 14 days, this was considered practical.

Pentothal

The first indication for pentothal was mentioned during the taking of the complete history, namely when recall of points of history was impossible. The second was when, during treatment, a plateau of improvement was reached or progress was not up to expectation. It was given as soon as indicated, and on an afternoon following insulin treatment.

The usual procedure was followed, *i.e.*, 1 cc per minute given to the stage of mild euphoria. The patient was then taken through his experiences in detail. If this did not produce any new information, he was simply asked to recount his most frightening and worst experience. Frequently this revealed hitherto repressed material. Immediately after termination of the pentothal, the patient was asked to recount his experiences while fully conscious and, when necessary, key ideas or names were supplied. In this way poorly organized material was systematized.

The results have proven to be beneficial in the majority of cases and in two instances severe stuttering disappeared on the termination of pentothal treatment.

Psychotherapy

This, of course, was the actual treatment and the continual cheerful, confident atmosphere played an important part. From the daily short interview at the termination of treatment, the need for additional interviews was determined and usually alternate days proved to be sufficient. To help the patient realize his responsibility in the treatment, he was urged to request his own interviews and to discuss problems as they arose.

There were 3 longer periods; first on admission, second the complete history and third about 2 days before discharge. In the latter talk certain mental hygiene principles were outlined: (1) The absolute inability to forget was explained and the common sense and necessity of accepting events that have happened in the past, no matter how unpleasant they were to face, were pointed out. (2) Patients were reminded how to relax. (3) They were instructed on the advisability of regular habits and sufficient sleep. (4) They were given suggestions on using up excess energy in physical activity. (5) We stressed the necessity of meeting problems and difficulties as they arose, rather than avoiding them by developing a neurotic reaction. (6) This led to a discussion of future employment and the probability of restlessness developing in the readjustment to civilian life. (7) Hobbies and other methods of utilizing spare time were outlined.

Obviously 10 days treatment cannot completely cure a condition of 2 years' duration, but we believe the short term treatment minimizes dependency on the doctor and prevents hospitalitis. We pointed out how they contributed to their own cure with our suggestion and guidance, and indicated how they could continue to improve by using the facts they had learned. They were made to realize that their future was their own and that they alone were responsible for it.

Estimation of Results

For purposes of classification, the results of treatment have been divided into 4 groups: (1) *Good*—disappearance of subjective complaints and objective signs, 38 cases (63%); (2) *Fair*—subjective complaints gone, but some evidence of slight tension such as occasional flushing or excess perspiration, 14 cases (23%); (3) *Mild*—diminution in subjective complaints and objective findings, 6 cases (10%); (4) *Poor*—no improvement, 2 cases (3%).

As expected, the incidence of complete recovery was much higher in the overseas group. In several cases of home service personnel, although superficial anxiety had been overcome there was a basic tendency toward neurotic symptoms and over-reaction to stress which would respond only to other and longer types of psychotherapy.

Summary and Conclusions

1. The technique of combined sub-coma insulin and pentothal narcosis in the treatment of 60 consecutive cases of prolonged anxiety was explained and the results analyzed.

2. Especially encouraging results have been obtained where the anxiety reaction has been superimposed upon a previously stable personality.

3. Although the superficial anxiety is usually all alleviated, if there have been long-standing emotional conflicts, more prolonged psychotherapy is usually necessary to influence them seriously.

4. Sub-coma insulin and pentothal should be looked upon as primarily supportive measures, but definitely serve to promote relaxation and to make the patient more receptive to psychotherapy.

5. It is felt that this form of treatment is practical in cases of prolonged anxiety reaction in civilian practice and is especially applicable to the treatment of this type of case on the wards of a general hospital.

THERAPEUTIC PEDAGOGY

A Neuropsychiatric Approach in Special Education [1]

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Special education can be defined as "a program of education adapted to the education of exceptional children" (Heck). According to Elise Martens, "the fundamental principle involved is that each child shall be educated in keeping with his capacities, limitations and interests, looking toward the happiest adjustment he can make in life and the most constructive he can bring to society."

The progress in the field of special education, since Itards' attempt, nearly 150 years ago, to teach an idiotic child the principles of understanding life and the habits necessary to adjust to society, has been tremendous. Yet every day brings new evidence of the need for special provisions for handicapped children in our school systems. Psychiatrists have been called upon to diagnose and recommend treatment programs in cases of behavior problem, psychopathic, and psychotic children. Neurologists have demonstrated interest in the problems of the epileptic, the palsied and in some instances the brain-injured child. Beyond the diagnosis and professional advice regarding specific therapeutic procedures in serious handicaps of exceptional children our profession has not entered the field of education proper.

One may state that this situation is correct. On the other hand, one should proudly recall that the early contributions in the field of special education came from physicians and psychiatrists. Itard was a physician for the deaf; his successor Seguin was a neurologist and psychiatrist. Samuel Gridley Howe, who did so much for the blind and the feebleminded, was a physician; Decroly and Montessori were psychiatrists, and one could add the names of many more. Physicians and psychiatrists not only lent their knowledge to effect behavioral adjustments within the school situation, but they contributed to academic training as well.

Let us consider for the moment the classroom situation. Any child experiences at least 8 years of schooling during which two main requirements are asked of him; first adjustment to and growth in a particular environment of social living, and second, acquisition to the extent of reasonable facility, of fundamental skills in the three R's. All other subjects are superstructures raised on these foundations or enlargements of these basic units.

Leading the mind to mastery of the academic skills rests with the teaching profession. However, in cases of physical handicap the teacher seeks assistance from other professions. The crippled child receives orthopedic care to improve the motor ability necessary for writing and other manual activities; the child who is deaf or hard of hearing receives a hearing aid to teach him the significance of communication by sound and language; the partially blind receives optic aides so that he can appropriate the instructional material. A large number of cerebral palsied and brain-injured retarded children need special aid to overcome the mental peculiarities which are the sequelæ of brain lesion.

To cite an example, outstanding pathological symptoms in the general behavior of brain-injured children are hyperactivity, distractibility, disinhibition and restlessness. This driveness is organic, does not yield to psychotherapeutic procedures, impedes the child's adjustment to the learning situation and obstructs his acquisition of the basic instruction. As an ultimate resort these children are referred to the attention of the psychiatrist. What can be done to alleviate the pathological behavior manifestation of these children?

If we establish a separate classroom, such as the one for brain-injured deficient children at the Wayne County Training School, and the one for cerebral palsied children in

[1] Read at the 102nd annual meeting of The American Psychiatric Association, Chicago, Ill., May 27-30, 1946.

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a public school—the Harvey Lowrey School in Dearborn—we can create a "therapeutic milieu" which is still a classroom and in which children can be taught in a group situation. Such a classroom is especially planned. All external distractions are either entirely removed or greatly diminished. No decorations are on the walls, the windows may be painted half-way to eliminate outside stimulation. The group is small (12 children is considered a maximum) and the room is very large so that each child can work at his own desk in not too close proximity to his schoolmate. Some children may work better when facing the wall, and in some instances the desk removed behind a hospital screen will give the child the necessary relief from external stimulation.

Within a few days the children recognize that all these changes are not a punishment procedure but part of a therapeutic environment. Their accomplishment increases, their interest in academic work is heightened, and since they now can learn, they are no longer the center of difficulties within the group. The more real knowledge and understanding of academic work the less prominent becomes the general disturbance of disinhibition. Comments regularly made by the children run like these: "I like it in this class because I can learn—I just couldn't stand so many kids in the other class." "May I sit behind the screen, I can work so much better." "May I sit at the desk against the wall, I get more work done." We must strongly emphasize that these arrangements do not produce withdrawal, autism or mannerisms because the brain-injured child, as any normal child, needs social contacts, enjoys group living, and returns to his group as soon as he feels himself no longer disturbed by the presence of other children. An academic success means much to these children who have had unpleasant experiences for one or many years before coming to this special class. All were considered difficult problems, "headaches" so to speak, for teachers and school administrators. Their lack of response to academic material, their disability in learning, was all the more puzzling since many of these children possessed a normal, or even above normal, intelligence.

More specific assistance can be given in the acquisition of academic learning by aiding the brain-injured child in the various fields of perceptual disturbances and in the motor field. Many of our devices, or, as the children call them, "gadgets" or "machines," are constructed to demonstrate through actual manipulation the fundamental processes of counting, writing or reading. For example, a child has not learned to count. The ability to determine the number of units in a group has not been achieved, either by practice with dot configurations or by pointing to the objects. The neuropsychiatrist, knowing developmental neurology, advises the teacher to construct a small frame standing upright. From the upper edge of the frame hang blocks on strings. The child grasps each block in sequence, at the same time saying the number name. Within a day his incoherent and inaccurate counting has disappeared. With his physical grasping of the blocks, he has for the first time mentally grasped the relationship of isolated units combined in a series. From then on he progresses with more elaborate problems of counting. Was this a trick? No. Developmental neurology tells us that in the maturation of coordinated movements grasping an object is genetically earlier developed than pointing to an object.

Here is another example in which neuropsychiatric thinking has helped. It is known that abductive movements of the arm and hand are more easily coordinated and more forceful than adductive movements. By beginning the teaching of writing with letters which are formed only by abductive movements as, "m," "n" or "r," rather than the letters, "a," "b" or "c," many a child has learned within a few days the beginnings of writing after weeks of vain struggle and frustration.

A number of brain-injured children are left-handed due to the fact that a right hemiplegia occurs more often than a left hemiplegia, and slight residuals from such motor handicap are often unrecognized. A neurological examination reveals the diagnosis. The change from left-handedness to right-handedness, in most instances, improves the child's reading disability and complete unresponsiveness to writing as well.

The following case history may illustrate our viewpoints:

Robert, a white boy, 10 years of age, was admitted to the training school because of severe misconduct attested to by parents, teachers and police department, and because of a serious learning disability. The diagnosis of brain-injury was established by the history of probable birth trauma, several accidents resulting in possible head injury, a positive neurological examination, and an abnormal electroencephalogram. This boy, previous to admission, had been examined by various psychologists, neurologists, and child guidance clinics because of his cruelty, his lack of discipline, his destructiveness in the community, his lack in learning all academic fundamentals, with particularly severe reading disability. Because of his intelligence quotient above 80, the teachers were especially puzzled. The diagnosis was psychopathy or social maladjustment resulting from unfavorable familial conditions; brain-injury was suggested as a possibility. The first few months in the training school gave ample proof of the correctness of all previous statements in regard to this boy's misbehavior and learning disability.

Our first examination revealed in addition to the facts already known, left-handedness, organic distractibility, erratic behavior on our tests specific for brain-injury. We suggested a special educational program according to our findings. After several months of attendance in the special class the behavior disturbances in school have all but disappeared, and his adjustment to group living in the cottage has markedly improved. He has learned as much as a normal child would accomplish in the same amount of time. We reported our findings to the administration as follows: "Robert has, according to history, certain experiences which may have caused brain-injury. The family history fits into this diagnosis—parents and siblings are of normal intelligence. Other factors corroborating our diagnosis are the positive neurological findings, abnormal electroencephalogram, and the results of our specific psychological tests. Against the diagnosis of brain-injury speak the statements by other physicians and psychologists who wish to explain the extreme misbehavior as a result of constitutional inferiority, psychopathy, and environmental familial influences. We cannot refute those statements because we feel that they are correct. The question, however, remains if there is an additional factor of brain-injury, and how much weight should be attributed to this factor. We have always maintained that brain-injury is only in rare cases the sole factor responsible for personality disturbances; however, we attribute to brain-injury more clinical valence than others do. We, therefore, feel that the present success in the academic situation is due to the diagnosis and the application of therapeutic pedagogy in a case of brain-injury."

To summarize our ideas on a neuropsychiatric approach in special education, we present the following points:

1. There are children in the group of exceptional children who need neuropsychiatric attention in the area of academic learning.

2. Establishing a special classroom, the creation of a "therapeutic pedagogical milieu" within the school system may sometimes be necessary.

3. Therapeutic pedagogy is not a substitute for, or a replacement of, other methods or procedures in special education. Children who need therapeutic pedagogy spend a period of a few months to several years in this special academic unit. They receive the benefits of a reduced school curriculum and an intensified teaching schedule for acquisition of fundamental academic skills.

Just as physiotherapy is specialized training in motor activity, therapeutic pedagogy is additional specified training in the field of basic academic learning.

4. At this time therapeutic pedagogy has proved valuable in the academic training of brain-injured children of the following types: the cerebral palsied child, the mentally retarded child, the deaf child, and the child with behavior maladjustment. Its efficacy has been shown in the whole range of educable intelligence from subnormal to above normal.

5. The neuropsychiatrist possesses the necessary knowledge and professional experience to assist teachers trained in the methods of therapeutic pedagogy in the solution of problems arising in educating these types of children.

We may lead the discussion a little further and ask why we stress the importance of academic learning in the group of exceptional children. If behavior adjustments could be achieved by lessening the burden of academic learning, would that not be preferable? We believe that a minimum proficiency in academic skills must be expected from everyone in our present-day civilization. This minimum requirement, however, should be achieved with the greatest ease and with least frustration.

Although our methods have helped only a relatively small group of the total group of exceptional children, we have indications that more intensive investigation and more research would enlarge this group by including many children of the so-called maladjusted, neurotic, or psychopathic type. We know that the same methods presented here

would not apply for such a larger group, but the philosophy underlying therapeutic pedagogy would remain the same. Ten years ago we defined therapeutic pedagogy in a book of the same title as follows:

> Therapeutic pedagogy has as its goal the education of children who suffer from retardation or disturbances in their development. Therapeutic pedagogy is based on medical knowledge of the causes and treatment of physical and mental defects in childhood. Therapeutic pedagogy comprises all methods which have as their goal a rehabilitation and harmonious development of capacities and aptitudes, physical as well as mental, of children and adolescents, crippled, blind, deaf, feebleminded, and psychopathic, from the point of view of establishing the necessary social habits which society at large expects.

COMMENT

JOURNAL BIOLOGY

The first issue of THE AMERICAN JOURNAL OF INSANITY, "edited by the officers of the New York State Lunatic Asylum, Utica," is dated July 1844. It was the first psychiatric periodical in the English speaking world, and founded and initially financed by Amariah Brigham, the newly appointed superintendent at Utica, who provided most of the contents of the first few numbers. The JOURNAL was a thin octavo brochure, each number to contain 96 pages and to be published quarterly. The subscription price was one dollar a year.

It is of interest to note the contents of this first issue of the JOURNAL. It opens with a "Brief Notice of the New York State Lunatic Asylum at Utica," with an illustration of the building. During the first 18 months operation 433 patients were admitted, of whom 123 were discharged recovered. Referring to the earlier New York Hospital in New York City, opened in 1791, the editor quotes *The Medical Repository* for 1807 to the effect that "the Lunatic Asylum of New York does honor to the city in which it stands, and the country to which it belongs. *It is believed that the proper discipline can be established among the maniacs, without the use of the whip.*"

Next follows a scholarly 38-page article, "Insanity—Illustrated by Histories of Distinguished Men, and by the Writings of Poets and Novelists," ranging from Homer to Walter Scott. Such notable case histories as those of Tasso, Cowper, Cruden, George III. are discussed in some detail; and the psychiatry of Shakespeare is extensively reviewed, The writer suspects that Shakespeare may have made his observations in Bedlam Hospital, and he sides with those who believe that Hamlet's madness was real.

An early example of the psychotherapeutic letter is reproduced. Sir James Mackintosh wrote under date of Feb. 18, 1808, to a clergyman friend on the recovery of the latter from a mental illness. In many respects the letter sounds quite modern. It suggests mental hygiene and prophylactic measures and is directed in particular to morale building. The letter concludes as follows: "May you, my dear friend, who have so much of the genius of Tasso and Cowper in future escape their misfortunes—the calamities incident to under sensibility, to grand enthusiasm, to sublime genius, and to intense exertion of intellect."

One section of the JOURNAL contains the abstracts of 10 interesting case histories, 2 of them of medico-legal import, doubtless representing patients at the Utica Asylum under Dr. Brigham's care.

He also makes a noteworthy comment on "Asylums Exclusively for the Incurable Insane." To correct the evils of the poor-houses and on grounds of economy certain individuals had proposed that "public asylums should be built on a cheap plan, solely for those supposed to be incurable." Brigham vigorously opposes this proposal and enumerates its disadvantages. Similar suggestions have been heard from time to time down to the present day and Brigham's comments are still pertinent. He feared that the establishments contemplated would be little better than the poor-houses they were intended to replace.

This first number closes with some statistics relative to the number of insane supported at public or private charge in the United States and certain European countries, together with data concerning the hospitals in the several states and a few brief notes and items of news. It is recorded that as of 1840 in 26 states, 3 territories (Florida, Wisconsin, Iowa) and the District of Columbia there were 17,457 hospitalized mental patients representing a total population of 17,069,453 (1 to 977).

Among the news items are mentioned the death at Leipsic of Heinroth at the age of 70, and the establishment by Baillarger, Cerise and Longet at Paris of a bimonthly journal, the *Annales Medico-psychologiques.*

From 1844 to 1894 the AMERICAN JOURNAL OF INSANITY was edited and published at the New York State Hospital at Utica and

was the property of that institution. In the semicentennial year the Association purchased the JOURNAL from the managers of the Utica State Hospital and it continued as the official organ of the Association, appearing four times a year.

The 50th annual meeting was memorable for the famous scolding administered to the membership by the guest speaker Weir Mitchell. It appears in full in the volume of *Proceedings* which was published separately. This volume contains a group of contributions surveying the achievements and personalities in psychiatry during the preceding 50 years.

At the 77th annual meeting in Boston in 1921, coincidentally with the name change whereby the American Medico-Psychological Association became the American Psychiatric Association, the JOURNAL was rechristened the AMERICAN JOURNAL OF PSYCHIATRY. At this time the Association which began its existence with the "Original Thirteen" founders has enrolled somewhat over 1000 members; and the JOURNAL, the first volume of which (1844-1845) numbered 386 pages, had grown in the 78th volume (1921-1922) to 725 pages.

The year 1921 was notable for the celebration of the 100th anniversary of the opening of Bloomingdale Hospital as a separate department of the New York Hospital, arranged by the superintendent Dr. William L. Russell. One of the distinguished speakers on this occasion was Dr. Lewellys F. Barker who gave an address on "The Importance of Psychiatry in General Medical Practice." Dr. Barker listed 8 reasons for the general practitioner's lack of interest in, or even aversion to, psychiatry. His address will repay re-reading (abstracted in the JOURNAL, July, 1921; published in full in "A Psychiatric Milestone," the official volume commemorating the centenary).

With volume 84 (1927-1928) the JOURNAL changed from a quarterly to a bimonthly publication. The editor, Dr. Edward N. Brush, in announcing the change and also the enlargement of the editorial staff, commented that his own connection with the JOURNAL had begun just 30 years previously. Dr. Brush had however participated in the editorial work during an earlier 6-year period at Utica, and when he retired in 1931 his total of 40 years on the editorial board far exceeded that of any other member before or since.

The death of Kraepelin (1856-1926) called forth from Dr. Adolf Meyer in the April 1927 number, both a critical survey of Kraepelin's work and a generous tribute to the versatile genius of this great German psychiatrist whose last thoughts before death concerned the fortunes of his Forschungsanstalt in Munich. His appeal to the Rockefeller Foundation for support was granted.

When Dr. Brush retired from the editorial chair in 1931, he wrote as his valedictory in the May issue an excellent 10-page review of the history of the JOURNAL from its founding by Amariah Brigham, who died at the early age of 50, after only 5 years as editor.

Having first become associated with the JOURNAL in 1878, Dr. Brush's remarkable memory of psychiatric developments in America down through the years lent great interest and value to his recollections, and it was hoped that a series of historical articles might come from his pen. Unfortunately he survived as editor emeritus only 2 years.

Biographies, with portraits, of the 7 former editors by Richard H. Hutchings and William Rush Dunton, Jr., together with a survey by Dr. Dunton of the JOURNAL's first hundred years, recording the changing complexion of subject matter as new interests, discoveries and procedures demanded attention, will be found in the Centennial Anniversary Issue published in 1944.

With rapidly increasing membership of the Association during the third quarter of its first century, and an ever widening range of contributors, the bulk of the JOURNAL had correspondingly enlarged. The last volume edited by Dr. Brush (1930-31) had reached 1086 pages.

The annual volumes, when bound, had become unwieldy; the 1940-41 volume ran to 1520 pages, almost a 50 percent increase in 10 years. On this account, and looking forward to the time when it would be desirable to increase the frequency of issue, the present format was adopted in 1941, a change that has proved advantageous in many ways.

At the Council meeting in December 1946, authority was granted for placing the JOURNAL on a monthly basis, and for engaging an assistant in the editorial office. Through the kind cooperation of Mr. Davies a very capable and experienced editorial assistant was secured in the person of Miss Martha V. Lavell, who came on the staff early this year and has already taken over a considerable share of the editorial responsibilities which have inevitably mounted year by year.

With the staff thus reinforced the changeover to the monthly schedule will now be possible and will begin with the present volume. Circulation of this issue will reach 5,816, of which considerably more than one-fifth (1,293) are paid nonmember subscriptions. We trust the increased frequency of the JOURNAL's appearance will be welcome to its readers and that its usefulness will thereby be enhanced.

NEWS AND NOTES

THE 1947 SOCIAL WORK YEAR BOOK.—According to the 84 experts who have contributed to the 1947 Social Work Year Book, social services of various types are being greatly expanded in the United States. There has been marked growth in such fields as health, education, recreation, and, of course, services to veterans. The public has been shocked out of its former apathy toward mental hygiene problems, as a result of war experiences; and much-needed reforms in mental hospitals through the "overdue" activities of laymen's organizations may now be anticipated.

An awareness is growing of the necessity for making social services available to all people in all economic groups. There is widespread agitation for health security for all; family agencies are offering family counseling services on a fee basis; and experts equipped to give advice on personal and family problems are found on the staffs of schools, churches, business and industrial firms, and trade unions. More than one-third of American adults have been shown by a nation-wide poll to be interested in some type of adult education. American cities of all sizes are demonstrating an unprecedented interest in long-range planning for recreation. As local, state, and federal services expand, voluntary agencies can devote more of their energies to pioneering and research, in such problems as alcoholism, for example.

In both voluntary and governmental agencies, the shortage of trained personnel is a major difficulty. Although between 1930 and 1940 the number of social workers in the United States increased 80%, there still remain 3 times as many professional positions in this field as there are qualified people to fill them. It is estimated also that the nation needs perhaps 40,000 more public health nurses than it has now. In spite of the general program of expansion, no Year Book contributor finds the growth in service keeping pace with demand or need.

The Social Work Year Book, edited by Russell H. Kurtz, is published biennially by the Russell Sage Foundation, 130 East 22d St., New York 10, N. Y.

REPORT OF THE NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE.—To the citizens of New York State, Dr. Frederick MacCurdy, Commissioner of Mental Hygiene, has addressed a progress report, listing the achievements of the Department for the past year. He pointed out that more than one-fourth of the state's annual operating budget is dedicated to the care of the mentally ill and proceeded to inform the citizens how this money was spent.

In addition, he stressed the objectives of the Department of Mental Hygiene as follows: (1) more and better qualified professional and nonprofessional personnel for the institutions, outpatient clinics, and administrative offices; (2) in-service training programs for all phases of department activities, from top to bottom; (3) improved food service, with more appetizing and nutritious menus and more economical use of foodstuffs; (4) a stepped-up program of prevention, to head off some of the flow of admissions to the hospitals; and (5) expanded research activities.

Included in the report was a summary of proposed building projects and plans for medical and surgical centers at a number of the state institutions. The upward trend in the population of the 26 mental institutions under the jurisdiction of the Department of Mental Hygiene has accelerated during the past year. By March 31 of this year these institutions were caring for a total of 105,210 patients, an increase of 1,921 over the past year.

NEW YORK INFIRMARY.—In connection with an expansion program to meet the growing needs of the New York Infirmary, it is pointed out that this was the first hospital founded by the first woman doctor in the United States, Dr. Elizabeth Blackwell. In the 94 years since its founding, the Infirmary has accumulated an impressive list of "first" occasions: the first training of

women doctors and women nurses in America; the first training of a Negro woman doctor; the first medical social service (which later became the Visiting Nurse Service); the first cancer prevention clinic anywhere in the world. The New York Infirmary is proposing to construct a new building, to cost 5 million dollars and to be located between 62d and 63d Streets at York Avenue, New York City. The hospital will have 350 beds and facilities for the care of at least 25,000 patients a year. It will be an international center for women in medicine.

OCCUPATIONAL INFORMATION ON PSYCHIATRY.—A new 6-page leaflet entitled "Psychiatry," by Florence L. Rome, has just been issued by Occupational Index, Inc., New York University, New York 3, N. Y. This pamphlet presents information on the growth of psychiatry, future prospects, description of the work, qualifications and preparation necessary, methods of entrance and advancement, salary ranges, number and distribution of doctors already in the field, advantages and disadvantages encountered. Sources of further information and selected references for additional reading are included. Cost of the pamphlet is 25 cents. Also available at the same price are leaflets on the subjects of medical social work, medical secretary, and practical nursing.

VETERANS ADMINISTRATION RESIDENCY IN PSYCHIATRY.—The Veterans Administration Hospital in New Orleans, Louisiana, is offering a 2-year residency in neuropsychiatry. This includes work with all phases of psychoses and psychoneuroses as well as the usual types of neurological and neurosurgical cases commonly found in a 500-bed hospital. The hospital has recently been designated a neurosurgery center. The residency will include 6 weeks' graduate study at Tulane University School of Medicine in neuroanatomy and neurophysiology. For information write to the Chairman of the Dean's Committee, Tulane University, 1430 Tulane Avenue, New Orleans 13, Louisiana.

WESTERN STATE PSYCHIATRIC INSTITUTE AND CLINIC.—The second annual Coordinating Conference of the Western State Psychiatric Institute and Clinic was held in Pittsburgh, Penna., April 10-11, 1947. The theme of this year's conference was the place of psychiatry in general medicine. General objectives of the Coordinating Conference are to coordinate the concepts and services of psychiatry, psychiatric nursing, clinical psychology, and psychiatric social service; to bring together and to further the work of the professional personnel in these fields; and to encourage the mutual contributions of psychiatry and general medicine.

GENERAL SEMANTICS SEMINAR.—The Institute for General Semantics will conduct its fourth annual seminar and workshop at Lakeville, Conn., from August 16 to September 5, 1947. Count Korzybski, members of his staff, and visiting lecture-consultants will participate in the program. The course is intended chiefly for those actively interested in the new methods of evaluation and their application to various fields of interest and work, including general and professional education, anthropology, psychiatry, mental hygiene, psychosomatic medicine, group work in rehabilitation, and general human relations.

The number of registrants will be limited to 50; applicants are expected to have some knowledge of the literature of general semantics. Registration fee is $50, which is credited to the $150 tuition charge. One full and five partial scholarships for the course will be granted by the Institute. For information concerning the 1947 seminar, write to Hansell Baugh, Registrar, Institute for General Semantics, Lakeville, Conn.

CORRECTIONS TO MARCH ISSUE.—From our list of the psychiatric resources of New York City, we regret that the Manhattan State Hospital was inadvertently omitted and the Lafargue Clinic was erroneously stated to be in the Bronx instead of Manhattan, where it in fact is.

BOOK REVIEWS

PERSONAL ADJUSTMENT. By *Knight Dunlap, Ph. D.* (New York and London, McGraw-Hill Book Company, Inc., 1946.)

Several years ago the reviewer was endeavouring to wade through some articles heavy with psychoanalytic terminology when he was fortunate enough to come across a small book with the arresting title: "Mysticism, Freudianism and Scientific Psychology" by an author then unknown to him by the name of Knight Dunlap. Recalling the reading of this book, the reviewer was prepared to read with pleasurable anticipation Professor Dunlap's recently published book on mental hygiene entitled "Personal Adjustment." He must confess, however, that he has been disappointed in some of the contents of this book, which consists of the lectures delivered by the author to his students in psychology at the University of California, modified and elaborated for the general reader.

In its 435 pages it purports to deal with such subjects as learning, studying, mental disorders, neurotic maladjustments, goals, readjustment, negative practice, sex, marital adjustment and maladjustment, care and training of infants and children, various minor maladjustments, and in a final chapter it presents a critique of psychoanalysis. All subjects are presented concisely and in very plain, though at times somewhat flippant, language. The author frequently expresses extremely categorical opinions on matters which to say the least are still considered highly controversial. Although not medically or psychiatrically trained, the author takes it upon himself to make frequent excathedra pronouncements on medical and psychiatric subjects. In so far as these refer to current psychiatric teaching and practice, they are neither up to date nor authentic.

An experienced psychiatrist is rather surprised to be told that "persons who do go insane do not recognize their symptoms and so do not worry about them." Another extraordinary statement is that "there is as yet no evidence that a person from a family in which there has been mental disorder is more apt to develop the disorder than one from a family in which the affliction has not yet appeared." The statement that "the cause of so-called color blindness appears to be a diet insufficient in animal proteins" does not accord with modern teaching.

The chapter on "mental disorders," in numerous places, illustrates the fallacy of a nonmedically trained psychologist giving his opinions on purely medical matters. What psychiatrist would talk of the "psychosis of tuberculosis," would consider the epileptic (untreated) as a safer driver of an automobile than a normal individual or would be willing to admit that a physician can do nothing for a case of idiopathic epilepsy? Multitudes of epileptics, symptom-free as a result of medical treatment, disprove such a statement. What psychiatrist would agree that "psychiatrists are of little use except for persons afflicted with serious mental disorders"? It is intriguing, if untrue, to be told that a patient in a major epileptic seizure is not unconscious but only suffers from a restriction of the field of attention. To one who has even a modicum of Latin, the spelling "extrovert" instead of "extravert" is extremely annoying. Notwithstanding all the medical judgments expressed by the author, on page 170, he naïvely remarks that "the psychologist, of course, does not pose as an expert on physical medicine," when that is just exactly what he has been doing throughout the whole book. Psychasthenics do not have delusions, and delirium tremens is not synonymous with multiple neuritis. There is certainly little truth in the statement that "most neurotics are vegetarians and have been vegetarians for the greater part of their lives." Incidentally vegetarianism seems to be one of the bugbears of the author, for he attributes to it neuroses, color blindness, and stammering. Other bugbears or "complexes" (if one dare use such a term) which the author seems to possess are semantics, Gestalt psychology, medical specialists, "commercial" psychiatrists by which he means practicing as opposed to institutional psychiatrists, and above all public enemy number one, psychoanalysis.

Notwithstanding the above critical comments, this book contains some very valuable material. The author's method of negative practise for the purpose of breaking habits and combating maladjustments is undoubtedly of great pragmatic value. He discusses sex and its functions and manifestations in human life in very plain language such as can readily be understood by any average intelligent person. His discussion of marital adjustment and maladjustment is also eminently practical and should be of great prophylactic value to young people contemplating matrimony, which, incidentally, is what the author intended it to be. The reviewer agrees with the author's designation of alcoholism as a habit rather than a disease which it is just now the popular thing to call it. His differentiation of personal maladjustment from social maladjustment on the basis of whether one's habits are disadvantageous to oneself or to others is a common-sense one.

In summary the reviewer is of the opinion that if the two chapters on mental disorders had been omitted, the book would have presented a safe, sane, and scientific (as well as a common-sense) teaching on the subject of personal adjustment and maladjustment.

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THE TREATMENT OF BRONCHIAL ASTHMA. By *Vincent J. Derbes and Hugo Tristram Engelhardt*, with chapters by a panel of contributors; (Philadelphia: J. B. Lippincott, 1946.)

Conservative evidence gleaned from this book indicates that approximately 75% of patients with bronchial asthma obtain marked relief from their asthmatic symptoms by allergy directed therapy. There remains a large number of asthmatics in whose picture allergens cannot be demonstrated and an additional number who, though allergen sensitive, do not respond to allergy directed treatment. Additional factors then, unknown stimuli perhaps, must also play a part in the production of bronchial asthma.

The importance of a reflex mechanism is indicated by the success of afferent sympathetic block (clearly discussed in Dr. Ochsner's chapter on surgical treatment); and that higher centers are involved in this reflex is suggested by ability of anaesthetic agents, as rectal ether, to control severe asthma paroxysms. For these reasons and for clinical observations described in this book, the psychiatrist must keep informed of available knowledge of bronchial asthma.

This book is not an encyclopedic compendium of our available knowledge of bronchial asthma, but it offers a good discussion of the allergens involved, their occurrence, distribution, and importance; and it presents a clear description of methods of diagnosis and treatment including brief chapters on psychiatric, rhinolaryngologic and surgical aspects. In addition, the first section of the book, labeled "Orientation," furnishes good background material in chapters on history (Ralph H. Major), statistics (Dublin and Marks), anatomy and physiology (G. E. Burch), immunology (M. B. Cohen), climate and weather factors (C. A. Mills), pathology and predisposing factors (the authors). Unfortunately, as in many books with chapters by a panel of contributors, what the book gains in authority it loses in duplication and in spotty writing.

The psychogenic factors are evaluated by Thomas M. French, clearly and concisely. He suggests that "psychologic factors may be effective either alone or by lowering the . . . . threshold of sensitivity to substances . . . . in the physical environment." Whatever the mechanism, psychodynamic studies reveal a common "undercurrent" in asthmatic patients, "a fear of loss of love and support of the mother" or mother substitute. With this background, possibility of brief psychotherapy exists, for "if the patient can confess the impulses that are at the moment responsible for his fear of estrangement from the mother substitute, then we may expect relief from his asthma attacks."

Certainly this book offers to the psychiatrist clinical and theoretical material essential for his understanding of bronchial asthma.

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SEX PROBLEMS OF THE RETURNED VETERAN. By *Howard Kitching, M.D.* (New York: Emerson Books Inc.)

This little book is a simple, nontechnical, rather idealistic discussion of marital adjustment and of the hazards inherent in prolonged separation, particularly the separation incident on overseas' service. It is not a description of serious aberrations, for, as the author states, the comments refer "primarily to good marriages." The problems, raised by separation, seem to be considerably less complicated than most of those which have come to our attention; so much so, that the title seems to be almost a misnomer.

The reader who seeks detailed or specific information as to the etiology, nature, or treatment of the sex problems of the returned veteran may be disappointed in this volume. He may feel also that much of what is said has been said too late, although it could have been of value, at an earlier date, in providing the soldier with some basis for the reasonable management of his sexual conduct.

Whether or not the book justifies its title it is a wholesome presentation written with an air of understanding and kindliness which is therapeutic in itself. It may serve the veteran and his wife by indicating the background of their present distress and by presenting a basis for readjustment. It contains many excellent comments and principles which can be applied to marriages in general. The clinician will not read it without wishing that married people could accept its viewpoint more wholeheartedly.

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BLACK ANGER. By *Wulf Sachs.* (Boston: Little, Brown and Company, 1947.)

Written by a South African psychoanalyst, this book is the biography of an African medicine man belonging to the Manika tribe of Southern Rhodesia.

"I carried out my studies of him chiefly by the classical method of free associations. He came every day for an hour at a time, lay down on the sofa, and was asked to say whatever came into his mind. Contrary to the usual analytical practice, I wrote down whatever he said in his actual phrases and in their actual sequences. . . . . These talks lasted, with a few interruptions, over a period of two and a half years."

However, the work does not present a deep psychoanalysis such as one might expect from such a procedure, nor is it an autobiography like those which some anthropologists have prepared. It is simply a readable life history narrated by a sympathetic listener. As such, it gives a useful account of some of the medical and supernatural beliefs of an atypical medicine man and his reactions to the social and cultural conflict between African and West European which confront the natives.

I did not have at my disposal for comparison a copy of his earlier book *Black Hamlet*, published in London during 1937. But from what I recall of that volume the present work seems to be essentially the earlier book with an added part at the end to bring the story up to date.

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The Vegetative System, Its Structure and Function. *Markelow, J.* (Odessa, U.S.S.R.) (Vrachebnoe Delo, 25(11-12): 511, 1945.)

Markelow states that the vegetative nervous system was and is usually studied for its structural arrangements, its physiological reactions, and its pathologic conditions. It is generally assumed that all the functions of the vegetative system, whatever they may be, are related to the well-established morphology and function of the sympathetic and parasympathetic systems.

By a more thorough analysis one may see that the functional status of the vegetative system is regulated also by some endogenous factors such as the electrolytes and hormones. In his estimation these endogenous factors act as a "correlative regulatory system" which is called also the "endocrinoioni-vegetative-complex."

The author, however, feels very strongly that in addition to the vitamins the "biologic organization" of the vegetative nervous system depends considerably upon exogenous factors such as "bioclimatic conditions." Furthermore, the whole human biology, as well as that of other animals, is influenced by environmental meteorism. Therefore a large number of "meteoro-biologic factors" have a fundamental importance in the development as well as organization of the vegetative functions, and only through their effects upon the organism is the rôle of the endogenous factors conditioned.

Among the "meteorologic factors" the author emphasizes particularly the action of the sun rays or the so-called "photones." Through the eyes they exercise their direct action upon the vegetative centers of the hypothalamus and hypophysis, and in this way an entire group of energetic processes is created, the most important regulator of which is represented by the "optico-vegetative system."

In conclusion, the author feels that the whole functional complex of the vegetative system, as indicated by the above-mentioned data and the hypotheses of Krauss, Hess, Muller, Bissonette, Benoi, etc., is related to the neurones with the receptors and effectors of the organs, the hormones, the ions (electrolytes), the vitamins and the photones, including also the recently discovered "inductors" or "organizers" (particular substances which seem to play an important rôle in the process of morphogenesis). Consequently it would result that the normal trophic and regulatory functions of the vegetative nervous system may be assured only through the complete participation of these various endogenous and exogenous components and their reciprocal correlation.

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Progress in Neurology and Psychiatry, an Annual Review. Edited by *E. A. Spiegel, M. D.* (New York: Grune & Stratton, 1946.)

With the present volume Dr. Spiegel inaugurates an annual review of the most important contributions to neuropsychiatric progress appearing during the previous year, surveyed with critical comment by able authorities in the various branches of the specialty. The first volume covers material published from December, 1944, to December, 1945, together with a smattering of hitherto inaccessible literature which appeared in the immediately preceding years. Since European publications have only recently begun to reenter channels of normal distribution, the coverage is predominantly Anglo-American and Latin-American, with just a hint of the interesting and important work accomplished in France and Russia during the war years. Future volumes will no doubt incorporate such work and give a more global picture.

As it stands, this is a splendid example of scientific reporting. It is more specialized, integrated, and critically oriented than the usual yearbooks and abstract services in the field, and it supplies a real need in our reference sources. The bulk of the contributions are in the field of neurology in the modalities of neuroanatomy, neurophysiology, neuropathology, neurosurgery, clinical and diagnostic neurology, all treated by different authorities in a many-faceted approach. Because of the multiple authorship and overlapping of territory, there is some repetition of material, but this is kept to a minimum. The section on psychiatry proper is more fragmentary than that in the neurological field, but the most important trends in the clinical, psychodynamic, and therapeutic fields are representatively treated.

Bibliographies are well chosen and extensive, enhancing the value of the review for research men and clinicians alike, for those in and out of touch with the literature of the day, and perhaps especially for men preparing for the Board examinations.

C. C. Burlingame,
Institute of Living, Hartford, Conn.

Sex, Marriage and Family. By *Thurman Rice, M. D.* (Philadelphia: J. B. Lippincott Co., 1946.)

The search for a sound orientation to sex and marriage in modern society on an acceptably realistic yet idealistic plane, and in terms and concepts comprehensible to the laity, should eventually be crowned with success, judging from the earnest and many efforts by reputable authorities in the

medical field. Dr. Rice has done a very creditable job in the present book, despite his inclusion of such fatuities for chapter and topical headings as "Alone at Last," "The Return from Elysium," "Learning the Art of Love," etc. There is a great deal of constructive material, judiciously presented for younger people, in almost every important phase of the marriage relationship. The chapters devoted to problems of wartime marriage are timely and in good perspective.

Books in this field are usually either too highly flavored with the psychiatric viewpoint to make any sense to laymen, or else they are neglectful of it altogether. Dr. Rice's book lies rather in the latter category. It is nevertheless a very superior production in its genre, combining an effective common-sense approach with sound medicine and unimpeachable ethics.

C. C. Burlingame,
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White Caps, the Story of Nursing. By *Victor Robinson.* (Philadelphia: J. B. Lippincott Co., 1946.)

After reading this book, my first thought was, "How I envy anyone who can treat a subject so thoroughly and in so much detail and still hold the interest of the reader." The type and format have been well chosen, the illustrations are excellent, and the manner in which the story is told is certainly very pleasing. The following paragraph taken from the introduction is an example:

"Woman is an instinctive nurse, taught by Mother Nature. The nurse has always been a necessity, and thus lacked social status. In primitive times she was a slave, and in the civilized era a domestic. Overlooked in the plans of legislators, and forgotten in the curricula of pedagogues, she was left without protection and remained without education. She was not an artisan who could obtain the help of an hereditary guild; there was no Hanseatic League for nurses. Drawn from the nameless and numberless army of poverty, the nurse worked as a menial and obeyed as a servant. Denied the dignity of a trade, and devoid of professional ethics, she could not rise above the degradation of her environment. It never occurred to the Aristotles of the past that it would be safer for the public welfare if nurses were educated instead of lawyers. The untrained nurse is as old as the human race; the trained nurse is a recent discovery. The distinction between the two is a sharp commentary on the follies and prejudices of mankind."

All the different chapters are full of readable information, and a tremendous amount of research must have been necessary in order to bring so many facts together. The subject is considered from the roots to the blossom, and the pleasant and unpleasant are given equal standing.

The writer says that the history of nursing is but a part of the history of woman, and he goes on to show how nursing has been one of the many avenues by which women have been emancipated. He describes in detail the origin of hospitals and follows closely the very gradual change from the untrained nurse of latter days to the well-educated professional of the present.

The chapters on Florence Nightingale, Clara Barton, and Edith Cavell are excellent and should be widely read. Nursing in wartime is well treated, and considerable space is given to the highlights of nursing care in all the great wars in which our country has been involved. The exploits of Dorothea Dix and Mother Bickerdye are unusually well done and make very interesting reading. The chapter on notable nurses of America furnishes information concerning Linda Richards, Rose Hawthorne, and other famous nurses, all of whom contributed much to the gradual development of the profession. A summary called "The March of the Nurse" and several pages of bibliographical notes make it more valuable to students.

White Caps is an excellent contribution to American literature which should be read by all nurses, both young and old. It could be used either as a text or a reference book, and it would be a valuable addition to all libraries, whether public or professional, as it is also recommended to the lay reader.

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Motor Disorders in Nervous Diseases. By *Ernst Herz, M.D., and Tracy J. Putnam, M.D.* (King's Crown Press, 1946.)

The scope of this book is rather wider than its title might suggest. Though originally prepared as an illustrated syllabus for study in conjunction with teaching films, it is a useful text by itself. Essentially, it is another work on principles and method of neurological examination, excluding the mental and sensory aspects. The first 6 short chapters cover motor functions of the limbs and trunk including reflexes. The sections on abnormal movements and gait are rather too brief to be of useful teaching value without the related moving picture films. There is a quite lucid brief account of the difficult subject of apraxia. The section on reflexes is well illustrated. The last 8 chapters deal with cranial nerves. There are many reproduced and original drawings and photographs with helpful schematic considerations of such subjects as diplopia, facial palsy, and vestibular disorders. The reviewer would recommend this book as an accessory reference manual and atlas for students and teachers. Because of its limited scope it cannot be used as a standard text on neurological method for students, but the ample collection of drawings and photographs makes it a good addition to any neurological library.

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